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EDITOR'S NOTE

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. 85-1043-CFX
atus: GRANTED

Title: Pilot Life Insurance Company, Petitioner
v.
Everate W. Dedeaux

cketed:
cember 16, 1985

Court: United States Court of Appeals
for the Fifth Circuit

Counsel for petitioner: Nolan Jr., John E.

Counsel for respondent: Denton, William L.

try	Date	Note	Proceedings and Orders
1	Dec 16 1985	G	Petition for writ of certiorari filed.
2	Dec 20 1985		Brief amicus curiae of American Council of Life Insurance and Health Insurance filed.
3	Jan 14 1986		Brief of respondent Everate W. Dedeaux in opposition filed.
4	Jan 22 1986		DISTRIBUTED. February 21, 1986
5	Jan 28 1986	X	Reply brief of petitioner Pilot Life Ins. Co. filed.
6	Feb 12 1986	X	Supplemental brief of petitioner Pilot Life Ins. Co. filed.
7	Feb 24 1986	P	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
8	May 30 1986		Brief amicus curiae of United States filed.
9	Jun 3 1986		REDISTRIBUTED. June 19, 1986
1	Jun 23 1986		REDISTRIBUTED. June 26, 1986
2	Jun 25 1986	X	Supplemental brief of respondent Everate W. Dedeaux filed.
3	Jun 30 1986		Petition GRANTED. The case is set for oral argument in tandem with No. 85-686, Metropolitan Life Insurance Company v. Taylor and No. 85-688, General Motors Corporation v. Taylor.
			**
5	Jul 22 1986		Order extending time to file brief of petitioner on the merits until September 6, 1986.
6	Jul 29 1986		Record filed.
7	Jul 29 1986		Certified original record and proceedings, 3 volumes, received.
8	Aug 20 1986	G	Motion of American Council of Life Insurance, et al. for leave to file a brief as amici curiae filed.
9	Sep 5 1986		Brief of petitioner Pilot Life Ins. Co. filed.
0	Sep 5 1986		Joint appendix filed.
1	Aug 27 1986		Opposition of respondent to motion of American Council of Life Insurance, et al. for leave to file a brief as amici curiae filed.
3	Sep 19 1986		Order extending time to file brief of respondent on the merits until November 4, 1986.
4	Oct 6 1986		Motion of American Council of Life Insurance, et al. for leave to file a brief as amici curiae GRANTED. Justice Scalia OUT.
5	Oct 31 1986		Brief of respondent Everate W. Dedeaux filed.
6	Nov 7 1986		CIRCULATED.
7	Nov 14 1986		SET FOR ARGUMENT. Wednesday, January 21, 1987. (2nd case)
8	Jan 12 1987	X	Reply brief of petitioner Pilot Life Ins. Co. filed.

PETITION FOR WRIT OF CERTIORARI

No. 85-1043

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

PILOT LIFE INSURANCE COMPANY,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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December 16, 1985

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QUESTIONS PRESENTED

(1) Whether the Employee Retirement Income Security Act ("ERISA") preempts state common law claims, including claims for punitive damages, based upon the alleged improper processing of a claim for benefits under an insured employee benefit plan by an insurance company serving as the plan's claims review fiduciary.

(2) Whether state common law causes of action of general application, sounding in tort and contract, are laws which regulate insurance under Section 514(b) of ERISA and thus saved from preemption.

(3) Whether, assuming that the state common law claims here involved regulate insurance, they nonetheless are preempted by ERISA, in conjunction with the McCarran-Ferguson Act, to the extent they conflict with provisions of ERISA regulating and providing remedies for the same conduct.

PARTIES TO THE PROCEEDING

Pilot Life Insurance Company*
Everate W. Dedeaux

* Pilot Life Insurance Company is wholly owned by Jefferson-Pilot Corporation. The following are companies that may be deemed affiliates of Pilot Life Insurance Company:

Jefferson Standard Life Insurance Co.
JP Investment Management Co.
Jefferson Pilot Investor Services Inc.
Jefferson Pilot Investment Inc.
Jefferson Pilot Pension Life Insurance Co.
Jefferson Pilot Life Insurance Co.
Jefferson Pilot Information Services Inc.
Jefferson Pilot Title Insurance Co.
Jefferson Pilot Fire & Casualty Co.
Jefferson Pilot Property Insurance Co.
Southern Fire & Casualty Co.
JP Growth Fund Inc.
Jefferson Pilot Growth Fund Inc.
JP Income Fund Inc.
Jefferson Pilot Income Fund Inc.
Jefferson Pilot Money Market Fund Inc.
Jefferson Pilot Communications Co.
Jefferson Pilot Communications Co. of Virginia
Jefferson Pilot Publications Inc.

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MISCELLANEOUS

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

No.

PILOT LIFE INSURANCE COMPANY,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

The Petitioner, Pilot Life Insurance Company, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit entered in this proceeding on September 16, 1985.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 770 F.2d 1311 (5th Cir. 1985), and appears in the Appendix ("App.") at 1a to 11a. The opinion of the United States District Court for the Southern District of Mississippi granting Petitioner's motion for summary judgment is unreported and appears in the Appendix at 16a to 18a.

JURISDICTIONAL STATEMENT

The judgment of the Court of Appeals for the Fifth Circuit was entered on September 16, 1985. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) (1982).

STATUTES AND REGULATIONS INVOLVED

This case involves sections 409, 502, 503 and 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1109, 1132, 1133 and 1144 (1982), the McCarran-Ferguson Act, 29 U.S.C. § 1012 (1982), and 29 C.F.R. § 2560.503-1 (1985) promulgated under ERISA Section 503. These provisions are reproduced in the Appendix at 35a to 50a.

STATEMENT OF THE CASE

Entex Inc. ("Entex") sponsors a Long-Term Disability Plan ("Disability Plan") for its employees which is governed by the Employee Retirement Income Security Act ("ERISA"). As plan sponsor and administrator, Entex is responsible for the Disability Plan's day-to-day operation and administration, including the provision of information and advice to employees regarding the plan's terms and coverage. Benefits under the plan, however, are provided through a group insurance policy issued by Petitioner Pilot Life Insurance Company ("Pilot Life"). Entex has delegated Pilot Life responsibility for processing claims for benefits under the Disability Plan.

Respondent, Everate W. Dedeaux, was an employee of Entex when he injured his back in March, 1975. Following this injury, respondent applied for and began receiving benefits under the Disability Plan. This plan provides an employee disability benefits for up to two years so long as he is prevented from performing the duties of his occupation. Following this initial two-year period, con-

tinued plan benefits are provided only if the employee is disabled from engaging in "*any and every* occupation or employment for which [he] is reasonably fitted by education, training or experience." (emphasis added)

Despite a number of differences and disputes, Pilot Life continued Dedeaux's disability benefits beyond the initial two-year period. However, in March, 1980, these benefits were terminated on the basis of independent medical reports indicating that Dedeaux was able to engage in certain types of light and sedentary employment.[1] Dedeaux did not appeal this decision to Pilot Life, which was vested with authority to conduct an appeal procedure under ERISA for denied claims. Rather, on May 30, 1980, Dedeaux filed suit against Entex and Pilot Life in the United States District Court for the Southern District of Mississippi based upon diversity of citizenship jurisdiction. His complaint, which included a request for a jury trial, alleged claims under Mississippi common law for breach of contract, breach of fiduciary duty and fraud. By way of relief, Dedeaux sought disability benefits, consequential damages for mental distress in the amount of $750,000, and an additional $500,000 in punitive damages.[2]

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[1] Prior to the termination of Dedeaux's benefits, there were significant questions as to his continued disability. Indeed, the Social Security Administration had terminated his social security disability benefits on the ground that he was no longer disabled from engaging in any gainful employment.

[2] Following suit, Pilot Life's Claims Review Committee reinstated Dedeaux's disability benefits retroactively based on a subsequent independent medical examination. After these benefits were resumed, Pilot Life received information that Dedeaux had engaged in a series of activities inconsistent with his claim of total disability, including carpentry work, operating a fruit stand, shrimping, moving furniture, and installing a fence and carpet, among others. Rather than terminating Dedeaux's benefits based upon this information, Pilot Life filed a counterclaim in the District Court for declaratory judgment and recovery of all disability payments improperly received by respondent.

Shortly after suit was filed, Entex successfully moved for summary judgment on the ground, *inter alia*, that it had delegated claims processing authority to Pilot Life and thus could not have breached any fiduciary duty owed Dedeaux. Pilot Life also sought summary judgment, arguing that any claim arising in connection with the processing of disability benefits under the Entex plan was governed by ERISA, and not by state law. On March 19, 1984, the District Court agreed and granted Pilot Life's motion, holding that ERISA preempted Dedeaux's state law causes of action and provided the "exclusive remedy" for Dedeaux's claims. App. at 18a.

On appeal, the Fifth Circuit reversed the District Court's order granting Pilot Life's summary judgment motion.[3] In so doing, the Court recognized that in view of the broad scope of ERISA preemption, "Dedeaux would have no claims outside of the ERISA scheme if Entex self-insured the Entex plan." 770 F.2d at 1314, App. at 6a. However, because the plan was insured by Pilot Life, the Court determined that Dedeaux's state common law contract and tort claims survived under Section 514(b) of ERISA which, in its view, exempted all state laws regulating insurance from ERISA's preemptive effect. It therefore concluded "that state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to, or coequal with any cause of action available under ERISA." 770 F.2d at 1317, App. at 11a.

In so holding, the Fifth Circuit relied principally upon this Court's decision last term in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985). There, after looking to analogous language in the McCarran-Ferguson Act, this Court interpreted the Section 514(b) "saving clause" to encompass a state insurance statute which regulated the contents of a group insurance policy, an area left unregulated by ERISA. In the Fifth Circuit's view, Dedeaux's state common law contract and tort claims likewise constituted "laws which regulate insurance" in that they "unquestionably affect[ed] the relationship between the insurer, the insured, and the beneficiaries." 770 F.2d at 1316, App. at 10a. It therefore concluded that these common law claims of general application, like the state insurance statute involved in *Metropolitan Life*, necessarily survived ERISA preemption under Section 514(b). The Court reached this conclusion notwithstanding that: (a) the remedies provided by state common law squarely conflict with those provided in ERISA and will have the practical effect of negating the federal remedies; (b) ERISA and its legislative history demonstrate that Congress intended federal standards to be the exclusive source of fiduciary law for all ERISA plans, insured and self-funded plans alike; (c) affording plan participants the option of pursuing state common law claims will undermine the statutory claims review procedures established by Congress in ERISA; and (d) neither the plain language of ERISA's saving clause nor the McCarran-Ferguson Act upon which it is based evidences an intent on Congress' part to exempt state common law claims of the type here involved from the broad scope of ERISA preemption.

[3] The District Court had certified its order granting Pilot Life summary judgment pursuant to Fed. R. Civ. P. 54(b) and entered final judgment accordingly. *See* App. at 13a-15a. No appeal was taken from the District Court's entry of summary judgment in favor of Entex.

REASONS FOR GRANTING THE WRIT

I. Review Of The Fifth Circuit's Decision Is Necessary To Restore Congress' Purpose To Provide Exclusive, Uniform Standards And Remedies In ERISA

ERISA is a "comprehensive and reticulated statute," *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361-62 (1980), enacted by Congress after years of careful study and debate "to remedy certain defects in the private retirement system." H.R. Rep. No. 533, 93d Cong., 1st Sess. 1 (1973), *reprinted in* Subcomm. on

Labor, Senate Comm. on Labor and Public Welfare, 2 Legislative History of the Employee Retirement Income Security Act of 1974, at 2348 (1976) ("Legislative History"). Among Congress' principal objectives in drafting ERISA was the elimination of the conflicting system of state and local regulation then governing the employee benefit field. *Id.* at 12, Legislative History at 2359; 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams); *id.* at 29197 (remarks of Rep. Dent). In its place, Congress sought to establish a single federal regulatory scheme for evaluating fiduciary conduct. *Id.* Congress accomplished this goal by formulating detailed federal standards to guide fiduciaries of all employee benefit plans, and by providing plan participants and beneficiaries with "six carefully integrated civil enforcement provisions," *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085, 3093 (1985), to secure their interests under federal law. To ensure that this pervasive federal framework would be preeminent, Congress expressly preempted, with certain narrow exceptions, all state laws which "relate to any employee benefit plan." ERISA Section 514(a), 29 U.S.C. § 1144(a) (1982).

Unless reversed, the Fifth Circuit's ruling will undermine this carefully crafted regulatory framework and the important principles of uniformity on which it is based. The distinction between insured and uninsured plans drawn by the Fifth Circuit in this context can only frustrate Congress' intent to establish a uniform source of federal law for evaluating fiduciary conduct. Moreover, by permitting state common law contract and tort actions to survive whenever an employee benefit plan is insured, the decision below will effectively repeal the civil enforcement remedies explicitly provided by Congress in a vast number of cases. This Court therefore should resolve the classic conflict between state and federal law created by the Fifth Circuit's ruling and reaffirm the balance struck by Congress in ERISA.

A. The Fifth Circuit's Ruling Undermines Congress' Intent To Establish Uniform Fiduciary Standards In ERISA

Review of the Fifth Circuit's decision is necessary to restore the primacy of federal regulation in the critical area of fiduciary conduct. In enacting ERISA, Congress replaced the conflicting system of state and local regulation of employee benefit plans with a "uniform source of law for evaluating . . . fiduciary conduct." Introductory Statement of Senator Javits on S. 1557, *reprinted in* 1 Legislative History at 279; *see* 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams); *id.* at 29197 (remarks of Rep. Dent); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983). To underscore the importance of federal control in this area, Congress not only establishd a detailed set of standards and duties to guide fiduciaries, *see* ERISA Section 404, 29 U.S.C. § 1104 (1982), but also vested the federal courts with *exclusive* jurisdiction over suits alleging a breach of fiduciary responsibility.[4] ERISA Section 502(e)(1), 29 U.S.C. § 1132(e)(1) (1982). In this manner, Congress hoped to enable fiduciaries administering interstate plans "to predict the legality of proposed actions without the necessity of reference to varying state laws." H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973), *reprinted in* 2 Legislative History at 2359; *see also* 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits). Moreover, Congress sought to eliminate "the need for interstate employers to administer their plans differently in each state

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[4] Moreover, ERISA also authorizes the Secretary of Labor to bring an action in federal court to redress a breach of fiduciary duty on behalf of a plan's participants and beneficiaries, § 502(a)(2), 29 U.S.C. § 1132(a)(2) (1982), and requires participants to serve a copy of the complaint on the Secretary of Labor, who is granted the right to intervene in such suits. § 502(h), 29 U.S.C. § 1132(h) (1982). These provisions similarly highlight Congress' desire to make federal control over fiduciary principles preeminent.

in which they have employees." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 105.

As this Court has recognized, ERISA's preemption provision lies at the heart of this effort to establish employee benefit plan regulation as "exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981); *see Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 99. Congress intended all state laws imposing fiduciary requirements on employee benefit plans to be displaced by the "comprehensive and pervasive Federal interest" identified in ERISA.[5] *See* 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits). To subject administration of such plans to the vagaries of state common law, accordingly, will undermine the very purposes underlying passage of ERISA Section 514.

Nor does ERISA itself draw any distinction between insured and self-funded plans for purposes of fiduciary standards as the Fifth Circuit has suggested. Congress carefully framed the definition of employee benefit plans to include *all* covered plans, including those established "through the purchase of insurance or otherwise."

[5] The legislative intent to preempt all state regulation of fiduciary conduct is well illustrated by H.R. 2, as reported by the House Committee on Education and Labor on October 2, 1973. It included the following preemption clause:

> It is hereby declared to be the express intent of Congress that, if any provision of this Act which relates to an aspect of fiduciary responsibility applies to a plan, then no State law which relates to the same aspect of fiduciary responsibility shall be applied to such plan.

Section 514(c)(1), H.R. 2, 93d Cong., 1st Sess. (1973), *reprinted in* 2 Legislative History at 2346. The Conference Committee ultimately rejected all such limited preemption provisions, applicable only to state laws relating to the specific subject matters covered by ERISA, in favor of a preemption clause superseding "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." § 514(a), 29 U.S.C. § 1144(a) (1982); *see Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98.

ERISA Section 3(1), 29 U.S.C. § 1002(1) (1982). Moreover, the statute is replete with references to insurance funding and administration of employee benefit plans, signifying Congress' recognition of the critical role insurance plays in the employee benefit field. *See, e.g.*, ERISA Sections 102(b), 103(a)(2), 401(b)(2), 29 U.S.C. §§ 1022(b), 1023(a)(2), 1101(b)(2); *see also* 29 C.F.R. § 2560.503-1 (1985). ERISA's plain language thus indicates that Congress intended to subject all employee benefit plans, including those funded through or administered by insurance companies, to the same pervasive federal regulation.

ERISA's legislative history confirms this view. ERISA, of course, "codifies and makes applicable" to all plan fiduciaries "certain principles developed in the evolution of the law of trusts." H.R. Rep. No. 533, 93d Cong., 1st Sess. 11 (1973), *reprinted in* 2 Legislative History at 2358. In formulating these federal fiduciary standards, Congress expressed strong concern that insured plans, because of the manner in which they were structured, generally had not been subject to the trust law principles it deemed essential to the adequate protection of the interests of plan participants and beneficiaries. Accordingly, Congress codified these federal "trust" principles, not only to ensure "uniformity", but to ensure that certain "plans, such as *insured* plans, which do not use the trust form as their mode of funding" would be subject to the same exacting standards. *Id.* at 12, Legislative History at 2359 (emphasis added). Thus, far from distinguishing between insured and self-insured plans, ERISA's legislative history makes clear that the Act's fiduciary standards were intended to provide the exclusive source of regulation in both instances.

B. The Lower Court's Holding Will Void The Express Civil Enforcement Remedies Provided In ERISA

If left uncorrected, the Court of Appeals' ruling will effectively void ERISA's enforcement scheme and, in particular, the civil remedies Congress has established. ERISA not only addresses the very areas of concern embodied in Dedeaux's state tort and breach of contract claims, but provides explicit federal remedies to correct and deter such putative violations. ERISA Section 502(a)(1)(B) specifically gives participants and beneficiaries a cause of action to recover benefits due under the terms of an employee benefit plan, or to enforce or clarify their rights thereunder. 29 U.S.C. § 1132(a)(1)(B) (1982). Similarly, participants or beneficiaries may file suit to enjoin any act or practice which violates either ERISA or the terms of the plan or "to obtain other appropriate equitable relief." ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3) (1982). Finally, ERISA provides participants and beneficiaries a cause of action in Sections 409 and 502(a)(2) for breach of fiduciary duty in the administration or management of the plan. 29 U.S.C. §§ 1109, 1132(a)(2) (1982). This detailed remedial scheme presents persuasive evidence that Congress did not intend to leave standing the additional state remedies authorized by the Fifth Circuit.

ERISA's statutory framework, moreover, is simply incompatible with the state common law claims made available by the lower court. ERISA not only makes fiduciary conduct a matter of exclusive federal concern, it requires *all* suits for fiduciary breach to be brought in federal court; the state courts are expressly denied any authority to hear such claims. ERISA Section 502(e)(1), 29 U.S.C. § 1132(e)(1)(1982).[6] Unlike state contract and tort actions, ERISA does not provide participants a right to a jury trial. *See, e.g., Calamia v. Spivey*, 632 F.2d 1235 (5th Cir. 1980); *Wardle v. Central States Pension Fund*, 627 F.2d 820 (7th Cir. 1980), *cert. denied*, 449 U.S. 1112 (1981); *Chastain v. Delta Air Lines, Inc.*, 496 F. Supp. 979 (N.D. Ga. 1980). Similarly, the standard of review is entirely different. In view of the internal claims review process mandated by the Act,[7] the federal courts do not conduct a hearing *de novo* on a participant's eligibility for benefits; rather, they engage in limited judicial review of the fiduciary's claims review decision to determine whether it was "arbitrary or capricious." *See Holland v. Burlington Industries*, 772 F.2d 1140, 1148 (4th Cir. 1985); *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182, 187 (3d Cir. 1984); *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454, 457 (6th Cir. 1984), *cert. denied*, 105 S. Ct. 786 (1985); *Fentron Industries v. National Shopmen Pension Fund*, 674 F.2d 1300, 1307 (9th Cir. 1982). Finally, and most importantly, ERISA, unlike state law, does not permit a participant to recover punitive or consequential damages for improper processing of benefit claims. *See Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085 (1985); *Bittner v. Sadoff & Rudoy Industries*, 728 F.2d 820 (7th Cir. 1984); *Zittrouer v. Uarco, Inc. Group Benefit Plan*, 582 F. Supp. 1471 (N.D. Ga. 1984); *Diano v. Central States Health & Welfare & Pension Funds*, 551 F. Supp. 861 (N.D. Ohio 1982).

The practical effect of the Fifth Circuit's decision will be to void ERISA's carefully crafted enforcement scheme

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[6] While ERISA permits actions for benefits under Section 502(a)(1)(B) to be brought in either federal or state court, it is clear that federal, rather than state law, controls their decision. *See* House Conf. Rep. No. 1280, Joint Explanatory Statement of the Committee of Conference on ERISA, 327, *reprinted in* 3 Legislative History at 4594; *Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1351 (8th Cir. 1980).

[7] ERISA mandates that employee benefit plans establish an internal claims procedure providing participants full and prompt review of any claims initially denied by a plan. ERISA § 503, 29 U.S.C. § 1133 (1982); 29 C.F.R. § 2560.503-1 (1985).

whenever an insured employee benefit plan elects to delegate processing of benefit claims to an insurance company. In such cases, a participant complaining of improper denial of benefits will be able to seek relief under ERISA, state common law or both. In sharp contrast, participants in self-funded and administered plans will be relegated *solely* to their federal remedies.[8] Faced with the unavailability of punitive or consequential damages and the more stringent standard of review applied under ERISA, participants in insurance funded or administered plans will have no incentive to pursue their federal rights, but will seek refuge in the more generous provisions of state common law. Indeed, one need look no further than this case to evidence this fact. As the Court of Appeals observed:

> the reason why Dedeaux did not pursue [his remedies under ERISA] is obvious. Dedeaux sought $500,000 in exemplary damages, but ERISA neither expressly nor implicitly authorizes such an award.

App. at 3a. Since a substantial portion of employee benefit plans are underwritten by insurance, the effect of this decision will be to shift responsibility for policing the private employee benefit plan system to the states. This displacement of federal control not only is contrary to Congress' design in fashioning ERISA's enforcement provisions, but will produce the very deleterious consequences which ERISA was enacted to avoid.

By permitting punitive and consequential damages claims against ERISA fiduciaries in this manner, the Fifth Circuit's decision also conflicts sharply with this Court's decision in *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085 (1985). In that case, which involved claims against an insurance company administering its own employee benefit plan, the Court held that ERISA Section 409 did not allow participants to recover punitive or consequential damages, based upon improper processing of a claim for disability benefits. Finding that ERISA's "six carefully-integrated civil enforcement provisions . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly," the Court declined to read into the Act a right to recover punitive damages or extra-contractual compensatory relief. 105 S.C. at 3093. In reaching this conclusion, the Court observed that ERISA's "interlocking, interrelated and interdependent remedial scheme," provides participants complaining of benefit claims denials with "a panoply of remedial devices at [their] disposal." *Id.* The Court therefore was "reluctant to 'fine-tune' an enforcement scheme crafted with such evident care as the one in ERISA." *Id.* By authorizing participants to sue ERISA claims review fiduciaries for punitive and consequential damages under the guise of state common law, the decision below reopens a door to recovery closed by this Court in *Massachusetts Mutual.*

[8] The Courts have concluded with virtual unanimity that ERISA Section 514 preempts state common law claims brought against self-insured plans. *See, e.g., Gilbert v. Burlington Industries*, 765 F.2d 320 (2d Cir. 1985); *Authier v. Ginsberg*, 757 F.2d 796 (6th Cir.), *cert. denied*, 106 S.Ct. 208 (1985); *Ogden v. Michigan Bell Telephone Co.*, 571 F.Supp. 520 (E.D. Mich. 1983); *Tolson v. Retirement Comm. of Briggs & Stratton*, 566 F. Supp. 1503 (1983); *Hayden v. Texas-U.S. Chemical Co.*, 557 F. Supp. 382 (E.D. Tex. 1983).

II. Unless Reversed, The Fifth Circuit's Decision Will Undermine The Claims Review Procedure Established By ERISA

The Fifth Circuit's decision frustrates yet another principle central to ERISA's statutory scheme—the orderly internal resolution of benefit claims disputes. Under ERISA Section 503 and regulations promulgated by the Department of Labor, all employee benefit plans, including insurance funded plans, are required to establish a reasonable internal claims procedure which provides for a "full and fair" review of decisions denying benefit

claims by an "appropriate named fiduciary." 29 U.S.C. § 1133 (1982); 29 C.F.R. § 2560.503-1 (1985). The obvious intent of this requirement is "to reduce frivolous claims, promote the consistent treatment of claims and create a non-adversarial method of claims settlement," thereby avoiding lengthy and expensive litigation. *Taylor v. Bakery & Confectionary Union International Welfare Fund*, 455 F. Supp. 816, 820 (E.D.N.C. 1978). To underscore the importance placed on these objectives, the courts generally have required plan participants and beneficiaries to exhaust the internal claims review procedure established by the plan, prior to filing suit. *See, e.g., Denton v. First National Bank*, 765 F.2d 1295, 1303 (5th Cir. 1985); *Mason v. Continental Group, Inc.*, 763 F.2d 1219, 1227 (11th Cir. 1985); *Kross v. Western Electric Co.*, 701 F.2d 1238, 1244-45 (7th Cir. 1983); *Amato v. Bernard*, 618 F.2d 559, 567-68 (9th Cir. 1980); *Bonin v. American Airlines, Inc.*, 621 F.2d 635 639 (5th Cir. 1980); *Challenger v. Local Union No. 1, International Bridge & Ironworkers*, 619 F.2d 645, 649 (7th Cir. 1980).

Regulations promulgated by the Secretary of Labor under Section 503 make clear that ERISA's claims review procedure fully applies to plans administered by insurance companies. Those regulations provide that an insurance company, such as Pilot Life, which is charged with review of denied claims, constitutes the "appropriate named fiduciary" for purposes of Section 503. *See* 29 C.F.R. § 2560.503-1(g)(2) (1985); *see also LeFebre v. Westinghouse Electric Corp.*, 747 F.2d 197, 203 (4th Cir. 1984); *Schulist v. Blue Cross*, 553 F. Supp. 248, 252 (N.D. Ill. 1982), *aff'd*, 717 F.2d 1127 (7th Cir. 1983). If participants may pursue state law breach of contract and tort actions against these fiduciaries for punitive and consequential damages, the practical benefits of such internal review will be negated. Benefit disputes would rarely, if ever, be finally resolved internally, since the prospect of litigation over punitive and consequential damages would linger even where a participant received all the benefits to which he was entitled in the review process. Even more importantly, participants, like the respondent in this case, could bypass the claims review procedure altogether, since state common law actions generally provide no such exhaustion requirement. Thus, ERISA's internal review procedure would be rendered meaningless merely because a plan chose to delegate review of claims for benefits to an insurance company.

III. The Fifth Circuit's Decision Plainly Misconstrued ERISA's Insurance Saving Clause And Requires Reversal By This Court

Relying upon this Court's opinion in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), and the McCarran-Ferguson Act, the Court of Appeals peremptorily concluded that respondent's state common law actions constitute laws which "regulate insurance" within the meaning of ERISA Section 514(b) and thus are "saved" from preemption. This construction of ERISA's saving clause not only is refuted by ERISA's legislative purpose and framework, but violates the plain meaning of its language. When that language is properly read in context with the similar language contained in the McCarran-Ferguson Act upon which it is based, the Fifth Circuit's misconstruction of the insurance saving clause is self-evident: Congress simply did not intend to exclude state common law actions of general application from the broad reach of ERISA preemption when it fashioned a limited exception for state laws regulating insurance.[9]

[9] The expansive breadth of ERISA's preemption provision has been noted on numerous occasions by this Court. *See, e.g., Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). Relying on the

As this Court observed last Term in *Metropolitan*, ERISA's insurance saving clause "appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S.Ct. at 2392 n.21. Both statutes "serve the same federal policy and utilize similar language to define what is left to the states." *Id.*[10] However, as the Fifth Circuit failed to recognize, the McCarran-Ferguson Act simply does not require federal deference to state common law actions. To the contrary, the state "regulation" of insurance contemplated by Congress embraces only *statutory* and *administrative* schemes of regulation, such as state insurance codes, specifically directed at the insurance industry. *See, e.g., SEC v. National Securities, Inc.*, 393

unmistakable dictate of Section 514(a), which provides for preemption of any state laws which "relate to" an employee benefit plan, the courts generally have concluded that all state action that directly affects plan administration has been superseded by federal law. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 95-98; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 522-25. Indeed, ERISA Section 514 has been described alternatively as a "virtually unique preemption provision," *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983), a provision of "unparalleled breadth," *Holland v. Burlington Industries*, 772 F.2d 1140, 1147 (4th Cir. 1958), and the "most sweeping preemption provision ever enacted," *California Hospital Association v. Henning*, 569 F. Supp. 1544, 1546 (C.D. Cal. 1938). Not surprisingly then, the fact that respondent's state common law actions "relate to" an employee benefit plan for purposes of ERISA's preemption provision was never in issue in the Court of Appeals.

[10] The McCarran-Ferguson Act provides in pertinent part: "[t]he business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a) (1982). The Act also makes federal antitrust laws applicable to the "business of insurance to the extent that such business is *not* regulated by state law." 15 U.S.C. § 1012(b) (1982) (emphasis added). ERISA's saving clause is similarly worded, exempting from preemption "any law of any State which regulates insurance." ERISA § 514(b), 29 U.S.C. § 1144(b) (1982).

U.S. 453 (1969); *Lowe v. Aarco-American, Inc.*, 536 F.2d 1160 (7th Cir. 1976); *Lawyers Title Co. v. St. Paul Title Insurance Corp.*, 526 F.2d 795 (8th Cir. 1975); *Crawford v. American Title Insurance Co.*, 518 F.2d 217 (5th Cir. 1975); *Steingart v. Equitable Life Assurance Society of United States*, 366 F. Supp. 790 (S.D.N.Y. 1973). When ERISA's saving clause is thus read *in pari materia* with the McCarran-Ferguson Act, the common law actions authorized by the Fifth Circuit clearly cannot stand.

Even apart from this distinction, common law actions of *general application* simply do not qualify as laws regulating the "business of insurance" under the McCarran-Ferguson Act and, by extrapolation, ERISA itself. This Court has made clear that "the core of 'business of insurance'" is the "relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement. . . ." *SEC v. National Securities, Inc.*, 393 U.S. 453, 459-60 (1969); *see also Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982). Thus, only "[s]tatutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'" *SEC v. National Securities, Inc.*, 393 U.S. at 460. More specifically, in enacting the McCarran-Ferguson Act, "Congress was mainly concerned with the relationship between insurance ratemaking and the antitrust laws, and with the power of the States to tax insurance companies." *Id.* at 458-59. Thus, Congress never intended that state laws of general application, or those only incidentally relating to the insurance business, should constitute state regulation within the meaning of the McCarran-Ferguson Act. *See, e.g., Hamilton Life Insurance Co. v. Republic National Life Insurance Co.*, 408 F.2d 606, 611 (2d Cir. 1969); *Hart v. Orion Insurance Co.*, 453 F.2d 1358, 1360 (10th Cir. 1971).

The state common law causes of action presented by this case—breach of contract, fraud and breach of fiduciary duty—plainly constitute state laws of the broadest general application, and not laws regulating insurance. Indeed, such actions are not limited to the insurance context, but have arisen in a variety of different proceedings unrelated to either insurance or the employee benefit area. *See, e.g., Gardner v. Jones*, 464 So. 2d 1144 (Miss. 1985) (fraud in lease agreement); *T.C.L., Inc. v. Lacoste*, 431 So. 2d 918 (Miss. 1983), (breach of contract for cemetery plot); *Tideway Oil Programs, Inc. v. Serio*, 431 So. 2d 454 (Miss. 1983) (breach of fiduciary duty and fraud in oil and gas lease dispute); *M.T. Reed Construction Co. v. Nicholas Acoustics & Specialty Co.*, 387 So. 2d 98 (Miss. 1980) (breach of construction contract); *First American National Bank v. Mitchell*, 359 So. 2d 1376 (Miss. 1978) (fraud and breach of duty of fairness by bank officer); *T.G. Blackwell Chevrolet Co. v. Eshee*, 261 So. 2d 481 (Miss. 1972) (fraud in purchase of automobile); *D.L. Fair Lumber Co. v. Weems*, 16 So. 2d 770 (Miss. 1944) (tortious breach of contract to pasture cattle). These common law actions no more constitute laws regulating insurance than traffic laws, defamation actions, negligence suits, criminal laws or other doctrines of general application. Moreover, had Congress intended to include such laws within the insurance saving clause, it could have easily so provided as it did in ERISA Section 514(b)(4) by exempting "any *generally applicable* criminal law of a State" from ERISA's premeption provision. *See* 29 U.S.C. § 1144(b)(4) (1982) (emphasis added).

In concluding that the saving clause operates to preserve state common law tort and contract remedies against an insurance claims administrator, the Court of Appeals also failed to take into account the "deemer clause" contained in Section 514(b)(2)(B) of ERISA, which provides that an employee benefit plan shall not

be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance." 29 U.S.C. § 1144(b)(2)(B) (1982). This significant qualification to the saving clause reflects Congress' commitment to free employee benefit plans from the possibility of state regulation through some artful or overly broad construction of the insurance exception. The clause makes explicit Congress' objective to foster uniformity in the employee benefit field by precluding *direct* regulation of employee benefit plans, irrespective of the funding mechanism adopted by the plan. When the deemer clause is thus read in conjunction with ERISA's legislative history, it is clear that state regulation directed to the administration of benefit claims or fiduciary obligations—regulation which strikes at the very core of ERISA—would be preempted, even where the plan is administered in part through an insurance company.

Any other construction would be difficult to reconcile with the legislative concerns expressed in ERISA. Surely nothing in the statute itself or its legislative history suggests that a participant's ability to pursue state common law remedies should turn on so facile a distinction as the funding mechanism for the plan or the plan administrator's decision to delegate claims review authority to an insurance company. To the contrary, by treating such insurance companies as the "named fiduciary" for purposes of Section 503, and subjecting them to the full range of federal requirements provided by ERISA, Congress acknowledged that these entities merely stand in the shoes of the Trustees of such plans, with the very same protections and liabilities. Inasmuch as such state common law actions would have no application if the plan were self-insured, *see* p. 12, n. 8 *supra*, no rational basis can exist for surrendering insured plans to virtually unlimited state regulation.

This Court's decision last term in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S.Ct. 2380 (1985) not only fails to support a contrary result, but illustrates the fundamental flaws in the lower court's holding. In that case, the Supreme Court was confronted with a "mandated benefits" statute requiring insurance companies to provide minimum mental health care benefits to Massachusetts residents insured under policies written in the state. In sharp contrast to the common law claims of general application at issue in this proceeding, the mandated benefits statute clearly qualified as a "law regulating insurance" under ERISA's saving clause and provided the very example of local regulation which the clause was designed to protect. Perhaps even more importantly, the subject matter of the state statute concerned an area not regulated by ERISA—the content of employee welfare benefit plans. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 91-92. Thus, the direct conflict between federal and state law, which necessarily provides the critical and decisive element in this controversy, was lacking.

The *Metropolitan Life* decision emphasizes, moreover, ERISA's proscription against *direct* state regulation of employee benefit plans. Acknowledging that the purpose of the deemer clause is to remove state laws that apply directly to benefit plans from the insurance exception, 105 S. Ct. at 2391-92, the Court observed that its decision would result "in a distinction between insured and uninsured plans, leaving the former open to *indirect* regulation while the latter are not." *Id.* at 2393 (emphasis added). The Court thus concluded that while insured plans could be indirectly subject to state laws which govern only the insurance company, like the mandated benefits statute, laws that directly regulate the employee benefit plan itself would be impermissible. Because state regulation of the actual payment of employee benefits, even when directed toward an insurance company acting as claims review fiduciary, would constitute such direct regulation, this activity must necessarily yield to federal law.

IV. In Any Event, Dedeaux's State Law Claims Are Preempted By Those Provisions Of ERISA Which "Specifically Relate" To The Business Of Insurance

Even if the state common law claims here involved could somehow be deemed laws "regulating insurance," they nonetheless would be preempted by application of ERISA and the McCarran-Ferguson Act. By its express terms, ERISA does not "alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." ERISA Section 514(d), 29 U.S.C. § 1144(d) (1982). One such pre-existing law is the McCarran-Ferguson Act. *See Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2392 n.21. While the McCarran-Ferguson Act generally permits the states to regulate the business of insurance, it does provide that federal legislation which "specifically relates" to the business of insurance will displace any conflicting state law. 15 U.S.C. § 1012(b) (1982).

As the Fifth Circuit recognized, ERISA's fiduciary responsibility and civil enforcement provisions proscribe and provide relief for the very actions Dedeaux complains of in this case—the wrongful denial of benefits under an insured employee benefit plan. 770 F.2d at 1316, App. at 11a. If, as the Fifth Circuit held, state common law claims proscribing and providing relief for this same conduct "affect the 'relationship between the insurer and the insured' " and thus lie at the heart of " 'the business of insurance' ", *id.*, App. at 10a, then *a fortiori*, ERISA also "specifically relates" to the business of insurance in this context. Accordingly, ERISA and the McCarran-Ferguson Act would operate in conjunction to preempt Dedeaux's state law claims. As the Ninth Circuit stated in an analogous context:

> Assuming arguendo that [the state law in question] is a state law regulating insurance . . . appellant's argument . . . ignores those ERISA sections that undeniably "specifically relate" to the business of insurance . . . . If McCarran-Ferguson applies, therefore, ERISA falls within the clause excepting federal laws that "specifically relate" to the business of insurance.

Hewlett-Packard Co. v. Barnes, 571 F.2d 502, 505 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

In short, the Fifth Circuit cannot have it both ways. If the state common law claims of general application here involved do not "regulate insurance," they clearly are preempted by ERISA Section 514(a) which supersedes any state law that "relate[s] to any employee benefit plan." 29 U.S.C. § 1144(a) (1982). Conversely, if the state common law claims do "regulate insurance," then they must fall before those provisions of ERISA which "specifically relate" to the same conduct. In either instance, review by this Court is essential to restore the primacy of federal law in this area and protect the delicate balance that Congress has struck.

V. The Questions Presented By This Petition Hold Important Implications For Insured Employee Benefit Plans That Should Be Addressed By This Court

The Fifth Circuit's decision undoubtedly will hold significant consequences for thousands of insured employee benefit plans across the country. Recent studies by the Department of Labor indicate that in the United States there are approximately 500,000 private pension plans, which alone cover over 50 million individuals, as well as an estimated 1.7 million sponsors of private employee welfare benefit plans. *See* U.S. Dep't of Labor, Labor Management Services Admin., Pension and Welfare Benefits Programs, Estimates of Participant and Welfare Benefits Programs, Estimates of Participant and Financial Characteristics of Private Pension Plans at 1 (1983); 4

Health and Population Study Center, Battelle Human Affairs Research Centers, Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-79 at 24 (1980). A significant percentage of these plans are insured. Still others generally are self-funded but purchase stop-loss insurance which provides for insurance funded benefits once a certain minimum benefit level is reached. Many of these plans, moreover, are multi-state in operation.

The claims review fiduciaries for these plans can be expected to process literally millions of claims for disability, pension and health benefits annually. A dispositive decision by the Court, accordingly, will be necessary to provide practical guidance to these fiduciaries as to their respective responsibilities under state and federal law. Moreover, intervention by this Court is critical to restore the carefully crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's civil enforcement remedies.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the judgment and opinion of the Court of Appeals for the Fifth Circuit.

Respectfully submitted,

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December 16, 1985

APPENDIX

APPENDIX

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

No. 84-4201

EVERATE W. DEDEAUX,
Plaintiff-Appellant,
v.

PILOT LIFE INSURANCE CO.,
Defendant-Appellee.

Sept. 16, 1985

Appeal from the United States District Court
for the Southern District of Mississippi

Before BROWN, WILLIAMS and GARWOOD, Circuit Judges.

JERRE S. WILLIAMS, Circuit Judge:

The case before us raises the question of whether the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1381 (1982), preempts an employee's common law breach of contract and tort claims against the insurance company that issued his employer's group insurance policy. The district court concluded that ERISA preempted the employee's claims. We reverse on the

authority of *Metropolitan Life Insurance Co. v. Massachusetts*, —— U.S. ——, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), decided after the decision of the District Court.

I

In March, 1975, Everate W. Dedeaux, an employee of Entex, Inc.[1] in Gulf Port, Mississippi, injured his back in a work-related accident. At the time of the accident, a long term disability benefits plan (Plan) Entex had established for its employees was in effect and purported to afford coverage for work-related injuries such as Dedeaux's. Entex established the Plan by purchasing a group insurance policy from Pilot Life Insurance Co.[2] Entex collected and matched its employees' contributions to the Plan and forwarded those funds to Pilot Life. Entex also bore responsibility for providing its employees with the necessary forms and documents for processing disability claims and forwarding those completed forms and documents to Pilot Life. Entex, however, possessed no discretion nor authority to determine who would receive disability benefits. Pilot Life alone possessed that authority. Entex's role was predominantly a ministerial one.

Dedeaux sought permanent disability benefits for the injuries he sustained in the March 1975 accident. Pilot

[1] On March 28, 1975, Dedeaux's employer of fifteen years, United Gas, Inc., became Entex, Inc.

[2] In ERISA, Congress authorized employers to create for their employees welfare benefit plans, including health and disability plans. *See* 29 U.S.C. § 1002(1). The employer may create or "fund" these plans in any one of three ways: (1) the employer absorbs the entire risk of loss, thereby becoming a self-insurer, (2) the employer purchases a group insurance policy from a commercial insurance company, or (3) the employer self-insures to a certain monetary amount and purchases from an insurance company a so-called "stop loss" policy to cover any claim over that amount. Entex used the second manner of funding its plan.

Life provided Dedeaux with benefits for the first two years after the accident but thereafter terminated benefits. For the next three years, Pilot Life repeatedly reinstated and then terminated benefits. Because of his frustration with Pilot Life, Dedeaux instituted this diversity action in 1980. Dedeaux sought $750,000 in compensatory and exemplary damages for Pilot Life's conduct and asserted claims under the Mississippi common law for breach of contract, breach of fiduciary duty, and fraud. Unlike the typical plaintiff litigating the status of his disability benefits, however, Dedeaux did not assert any claim under ERISA.[3] *See, e.g.*, 29 U.S.C. § 1132 (1982) (identifying myriad causes of action for a fiduciary's failure to pay benefits).

After the close of discovery, Pilot Life moved for summary judgment, asserting that the group insurance policy it issued to Entex was an employee benefit plan governed exclusively by ERISA.[4] According to Pilot Life, ERISA therefore preempted any common law claim for its failure to pay disability benefits. The district court found that section 514(a) of ERISA expressly preempted Dedeaux's causes of action and accordingly granted Pilot Life's motion for summary judgment.

[3] The reason why Dedeaux did not pursue this tack is obvious—Dedeaux sought $500,000 in exemplary damages, but ERISA neither expressly nor implicitly authorizes such an award. *See* 29 U.S.C. §§ 1109(a) & 1132(a); *Massachusetts Mut. Life Ins. Co. v. Russell*, —— U.S. ——, 105 S.Ct. 3085, 3094, 86 L.Ed.2d —— (1985); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1216 (8th Cir.), *cert. denied*, 454 U.S. 968, 102 S.Ct. 512, 70 L.Ed.2d 384 (1981). Mississippi common law, however, authorizes such an award in certain circumstances. *See Tideway Oil Programs, Inc. v. Serio*, 431 So.2d 454, 460 (Miss. 1983) (fraud); *Bryan Constr. Co. v. Thad Ryan Cadillac, Inc.*, 300 So.2d 444, 449 (Miss. 1974) (fraud).

[4] Benefits under the Mississippi Workers' Compensation Law, Miss.Code Ann. §§ 71-3-1 to 71-3-113 (1973 & 1984 Supp.) are not at issue in this case. Entex appears to have procured the disability policy to include benefit coverage supplemental to the compensation statute.

II.

A.

The narrow question in this appeal is whether Dedeaux's tort and contract claims are saved from preemption by section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Answering this question necessarily requires us to interpret the delicate balance between several critical provisions of section 514. In pertinent part, Section 514 provides:

> (a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)] of this title and not exempt under section 4(b) [29 U.S.C. § 1003(b)] of this title. . . .
>
> * * * *
>
> [(b)](2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> [(b)(2)](B) Neither an employee benefit plan described in section 4(a) [29 U.S.C. § 1003(a)] of this title, which is not exempt under section 4(b) [29 U.S.C. § 1003(b)] of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Section 514(a), the "preemption" clause, embodies the general rule of preemption and speaks in sweeping

terms. Section 514(b)(2)(A), or the so-called "saving" clause, limits the scope of the preemption clause and essentially states that ERISA does not preempt any state law that regulates "insurance, banking, or securities." Section 514(b)(2)(B), the "deemer" clause states, in part, that no benefit plan shall be construed to be an insurance company or engaged in the business of insurance for the purpose of any state law regulating insurance matters.

Dedeaux asserts that his causes of action against Pilot Life constitute laws "which regulate[] insurance" and therefore are saved from the general rule of preemption.[5] Pilot Life answers with five separate but related arguments supporting its conclusion that preemption is mandated in this case. First is Congress's preeminent intent to maintain national uniformity in the maintenance and administration of ERISA plans. It is argued that permitting plan participants and beneficiaries to assert state-created claims instead of or in addition to their causes of action under ERISA subjects insurers and the plans they insure to additional exposure to liability as well as a variety of duplicative, inconsistent, or conflicting state regulations. The varied panoply of rights, it is urged, defeats Congress's stated desire to ensure that plans are administered on a uniform, nationwide basis. Second, it is asserted that Congress sought to have the exceptions to the otherwise broad rule of preemption construed narrowly. Under such a reading, Pilot Life asserts that common law causes of action such as Dedeaux's simply cannot be construed to be "law[s] . . . which regulate[] insurance." Pilot Life views this count as a natural corollary to its first claim.

[5] In finding that ERISA preempted Dedeaux's claims, the district court apparently did not consider the manner in which the saving clause operated to limit the preemption clause in this case. It dismissed Dedeaux's case merely upon the breadth of the preemption clause.

In its third argument, Pilot Life urges that to hold otherwise would create an irrational and indefensible distinction between plans that are self-insured and those that are insurance-funded. *See supra* n.2. This result occurs if Dedeaux's claims fall within the saving clause. There is no question that because of the deemer clause, which limits the effect of the saving clause, Dedeaux would have no claims outside of the ERISA scheme if Entex self-insured the Entex Plan. Why, Pilot Life asks, should plan beneficiaries and participants be afforded additional rights and remedies merely because Entex purchased an insurance policy to create the Entex Plan?

Pilot Life's fourth argument is that the deemer clause substantially limits the scope of the saving clause and operates to save from preemption only so-called "traditional" insurance laws. Pilot Life defines traditional insurance laws as including those governing the sale of stock, the licensing of agents, or the maintenance of minimum capital reserves. Non-traditional insurance laws and those that would be preempted are any laws that mandate the inclusion of substantive benefits in policies sold to plans or those that create separate rights or a remedial scheme outside ERISA.

Pilot Life's fifth argument merits particular attention as later analysis reveals. In this final argument, Pilot Life asserts that ERISA specifically proscribes and creates a cause of action for the conduct in which Dedeaux alleges Pilot Life engaged. It is urged, therefore, that Congress certainly did not intend to enable states to enact separate laws proscribing the same conduct.

B.

Our holding on this appeal turns upon the Supreme Court's recent decision in *Metropolitan Life Insurance Co. v. Massachusetts*, —— U.S. ——, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985). In *Metropolitan Life*, the Court for the first time interpreted the meaning and scope of the saving clause. *Metropolitan Life* involved the challenge mounted by two insurance companies against a Massachusetts statute that required all insurers, including those who sold policies to employee benefit plans, to provide insurance coverage for mental health care services. The insurer attacked the validity of the so-called mandated benefit law by raising the same arguments Pilot Life raises here. A unanimous Supreme Court rejected the insurers' arguments and upheld the validity of the statute. In so doing, the Court clearly and unequivocally repudiated the first four arguments Pilot Life raises here.

The Court began its analysis of the preemption question with the following aphorisms—(1) the ordinary meaning of the language of the statute expresses congressional intent, (2) unless the statute explicitly and clearly states otherwise, Congress does not intend to preempt areas which states traditionally have regulated, (3) federal statutes are not presumed to preempt state laws, and (4) courts should not read limitations into a statute to enlarge the statute's preemptive scope. The opinion then noted that the Massachusetts statute appeared to be a law that regulated "insurance" and therefore would fall squarely within the saving clause. The Court proceeded to analyze the statute and its legislative history and found nothing in either supporting a narrowing of the saving clause. The Court led itself to conclude that the insurers' interpretation of the statute would render the saving clause meaningless.

The Court, however, went beyond the mere lack of legislative or statutory support for the insurers' arguments. It analyzed by way of comparison the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1982). That statute, which was enacted originally in 1945, states in pertinent part:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of

> the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supercede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.

15 U.S.C. § 1012. The Supreme Court on numerous occasions has interpreted the McCarran-Ferguson Act and emphasized that the primary concern of that act was to "ensure that the States would continue to have the ability to tax and regulate the business of insurance." *Group Life and Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 217-218, 99 S.Ct. 1067, 1076-1077, 59 L.Ed.2d 261 (1979). The latter act and the interpretations thereof were seen to provide support for the opinion's conclusion that state laws regulating the substantive terms of insurance policies sold to ERISA-authorized benefit plans are saved from preemption by the saving clause. *See Metropolitan Life*, —— U.S. —— at —— & —— n.21, 105 S.Ct. at 2391 & 2392 n.21. The Court explicitly rejected the insurers' argument that the deemer clause operated to limit the saving clause and save from preemption only "traditional" state insurance laws. —— U.S. at —— & ——, 105 S.Ct. at 2390 & 2391. And the opinion paid short shrift to several of the insurers' remaining arguments favoring preemption. The Court recognized and quoted statements made in the floor debate about the "narrow" exceptions to the preemption clause, but found that these references were "far too frail a support" for the insurers' interpretation of the saving clause. —— U.S. at ——, —— & n.24, 105 S.Ct. at 2392, 2393 & n.24. The opinion additionally noted:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the

> latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter. We also are aware that [the insurers'] construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.

—— U.S. at ——, 105 S.Ct. at 2393. And finally the Court said:

> We therefore decline to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the "deemer clause" which modifies it. If a state law "regulates insurance," as mandated-benefit laws do, it is not preempted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause, *whether it be the Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA*, or the insurers' more speculative attempt to read the saving clause out of the statute.

——U.S. at ——, 105 S.Ct. at 2393 (emphasis added). In summary, the Court read the saving clause broadly and the preemption and deemer clauses narrowly.

The Supreme Court's disposition of similar issues in *Metropolitan Life* makes it unnecessary to analyze in detail Pilot Life's first four arguments favoring preemption. Pilot Life, however, raises as its fifth argument one that the Supreme Court did not consider expressly. Pilot Life asserts that since Congress proscribed the conduct which Dedeaux alleges Pilot Life committed—wrong-

ful failure to pay insurance benefits—and created causes of action for the commission of that conduct,[6] Congress did not intend state laws proscribing the same conduct to survive.

We must disagree. The plain language of the statute supports the contrary result. Pilot Life does not argue seriously that state law causes of action for the nonpayment of insurance benefits are not laws "which regulate[ ] insurance." In interpreting the similar phrase, "regulation [of] . . . the business of insurance," the Supreme Court in *SEC v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969), concluded that laws affecting the "relationship between the insurer and the insured . . . [are] 'the core of the business of insurance.'" *Id.* at 460, 89 S.Ct. at 568, *cited with approval in Metropolitan Life*, —— U.S. at ——, 105 S.Ct. at 2391. The instant causes of action unquestionably affect the relationship between the insurer, the insured, and the beneficiaries and therefore are laws which regulate insurance. Under the plain language of the statute, therefore, Dedeaux's causes of action for Pilot Life's failure to pay insurance benefits rely upon laws "which regulate[ ] insurance and fall squarely within the saving clause.

Pilot Life answers with the ipsi dixit argument that "Congress could not have intended to permit states to do the same thing as it did in ERISA." Nothing in the statute or its legislative history, however, supports Pilot Life's argument. Indeed, the Court in *Metropolitan Life* held that "[i]f a state law 'regulates insurance' . . . it is not preempted." —— U.S. at ——, 105 S.Ct. at 2393. The analysis of whether a particular law is saved from preemption ends once it is determined that a law falls

[6] *See* 29 U.S.C. § 1132(a) (creating cause of action for breach of fiduciary duty, wrongful termination of benefits, and wrongful failure to pay benefits).

within the saving clause and is not exempt by the narrow deemer clause. —— U.S. ——, 105 S.Ct. at 2393. And given the repeated reaffirmance and application of the forty year old McCarran-Ferguson Act, which in essence states that insurance matters are areas of state concern absent a clear congressional statement to the contrary, clear and precise words by Congress would be required to disgorge states of their long-held ability to proscribe and create a cause of action for an insurer's failure to pay insurance benefits.

We are left with the unavoidable conclusion that state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to, or coequal with any cause of action available under ERISA. *See Eversole v. Metropolitan Life Insurance Co.*, 500 F.Supp. 1162, 1170 (C.D.Cal.1980). Dedeaux's common law causes of action for Pilot Life's failure to pay disability benefits, therefore, are not preempted. We are not unmindful of the practical consequences of this decision. As the Supreme Court stated in *Metropolitan Life*, however, those concerns must be directed to Congress.

The district court's order granting Pilot Life's motion for summary judgment must be set aside.

REVERSED AND REMANDED.

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 84-4201

EVERATE W. DEDEAUX,
Plaintiff-Appellant,

versus

PILOT LIFE INSURANCE COMPANY,
Defendant-Appellee.

Appeal from the United States District Court for the Southern District of Mississippi

[Filed Aug. 17, 1984]

Before REAVLEY, POLITZ and JOLLY, Circuit Judges.

BY THE COURT:

IT IS ORDERED that Appellee's motion to strike portions of appellant's brief, is moot.

IT IS FURTHER ORDERED that appellee's motion to dismiss the appeal, is considered and the court grants a limited remand to the district court for the opportunity for that court entering either a final judgment or a Rule 54(b) order. If that is not done and filed with the clerk of the court of appeals by September 4, 1984, the appeal will be dismissed.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

Civil Action No. S80-0467(R)

EVERATE W. DEDEAUX,
Plaintiff,

vs.

PILOT LIFE INSURANCE COMPANY,
Defendant.

[Filed Aug. 22, 1984]

FINAL JUDGMENT

This cause came on to be heard upon a limited remand to this Court from the United States Court of Appeals, Fifth Circuit, for the opportunity to enter either a final judgment or a Rule 54(b) order, and the Court, having considered this matter, is of the opinion that final judgment should be entered pursuant to a certification under Rule 54(b).

IT IS THEREFORE ORDERED AND ADJUDGED that the final judgment be entered in this cause for the Defendant, Pilot Life Insurance Company, and against the Plaintiff, Everate W. Dedeaux, with all costs herein assessed to Plaintiff.

SO ORDERED AND ADJUDGED this the 22nd day of August, 1984.

/s/ Dan M. Russell, Jr.
United States District Judge

Approved As To Form:

Ronald S. Cochran
Attorney for Plaintiff
George F. Woodliff
Attorney for Defendant

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

Civil Action No. S80-0467(R)

EVERATE W. DEDEAUX,
Plaintiff,
vs.
PILOT LIFE INSURANCE COMPANY,
Defendant.

[Filed Aug. 22, 1984]

CERTIFICATION UNDER RULE 54(b)

This cause came on to be heard upon a limited remand to this Court from the United States Court of Appeals, Fifth Circuit, for the opportunity to enter either a final judgment or a Rule 54(b) order, and the Court, having considered this matter, is of the opinion that certification under Rule 54(b) should be granted.

IT IS HEREBY CERTIFIED, in accordance with Rule 54(b), Fed.R.Civ.P., (1) that the Court has directed the entry of final judgment as stated in the attached order entitled Final Judgment; and (2) that the Court has determined that the claims so certified are separable and there is no just reason for delay.

In support of this certification, the Court makes the following findings:

1. On March 19, 1984, this Court rendered its opinion in this case.

2. The Court in its opinion denied all of the Plaintiff's claims asserted in his Complaint.

3. The Court did not rule on the counterclaim asserted by Defendant.

4. The Court has determined that the claims asserted in the Plaintiff's Complaint are separable from the claim asserted in Defendant's counterclaim and that there is no just reason for delay in the appellate resolution of the Plaintiff's claims.

5. Sound judicial administration and equity require certification.

THIS, the 22nd day of August, 1984.

/s/ Dan M. Russell, Jr.
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

Civil Action No. S80-0467(R)

EVERATE W. DEDEAUX,
Plaintiff

vs.

PILOT LIFE INSURANCE COMPANY,
Defendant

OPINION

This cause is presently before the Court on the defendant Pilot Life Insurance Company's motion to reconsider the Court's denial of its motion for summary judgment. At this time the Court finds it must grant the defendant's motion for summary judgment.

The plaintiff (Dedeaux) seeks recovery on three counts: tortious breach of contract, breach of fiduciary relationship and fraud in the inducement. In 1960, Dedeaux became employed by Entex, where he was insured by the defendant company (Pilot Life) through a group disability policy. On March 26, 1975, Dedeaux was permanently and totally disabled while attempting to lift an air conditioner. Dedeaux's claim was filed in November, 1975, and he began to receive benefits. After various contretemps with Pilot Life, Dedeaux's benefits were terminated on March 14, 1980. Thereafter, this suit was filed.

Pilot Life claims that the action is preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, since it is based on state law.

In its ruling denying the motion for summary judgment, the Court relied on two fairly recent opinions. *Anderson v. Connecticut General Life Insurance Co.*, No. J80-0136(R) (S.D. Miss. June 8, 1981); *Eversole v. Metropolitan Life Ins. Co.*, 500 F.Supp. 1162 (S.D. Miss. 1980). The Court believed that *Allessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1980) was distinguishable. In reviewing the Circuit's recent pronouncement on the subject in *Hayden v. Texas-U.S. Chemical Co.*, 681 F.2d 1053 (5th Cir. 1982), the Court discovered that *Hayden*, which contained facts similar to those *sub judice*, had been remanded for the district court to consider and decide whether Hayden's claim was governed by ERISA. *Id.* at 1057. At the time of its ruling, this Court was unaware that the case had been decided on remand, since the opinion was not yet available to the Court.

On remand in *Hayden*, 557 F.Supp. 382 (E.D. Texas 1983), the district court found that the disability plan was covered and preempted by the provisions of ERISA. Since the two fact situations are somewhat similar, the Court must necessarily lend credence to the *Hayden* decision. As in *Hayden*, this Court must find that this particular plan does not meet any of the ERISA exemptions found in 29 U.S.C. § 1003(b) (1976).[1] Further, the

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[1] The applicable section provides:

(b) The provisions of this subchapter shall not apply to any employee benefit plan if—

(1) such plan is a governmental plan (as defined in section 1002(32) of this title);

(2) such plan is a church plan (as defined in section 1002(33) of this title) with respect to which no election has been made under section 410(d) of Title 26;

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws

plan is within the definition of an "employee welfare benefit plan" at 29 U.S.C. § 1002(1).[2] The Court must conclude that the Pilot Life plan is governed by ERISA; therefore, the Court must disregard state law.

Since each of Dedeaux's claims is based on state law, Pilot Life's motion for summary judgment must be granted. Dedeaux's exclusive remedy lies under ERISA.

An order in accordance with the opinion of this Court shall be submitted as provided for in the Local Rules. This the 19th day of March, 1984.

/s/ Dan M. Russell, Jr.
United States District Judge

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or unemployment compensation or disability insurance laws;

(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

(5) such plan is an excess benefit plan (as defined in section 1002(36) of this title) and is unfunded.

[2] The section provides in pertinent part:

(1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, ...

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

Civil Action No. S80-0467(R)

EVERATE W. DEDEAUX,
Plaintiff

vs.

PILOT LIFE INSURANCE COMPANY,
Defendant.

MEMORANDUM OPINION

This cause is presently before this Court on the Motion of Pilot Life Insurance Company (Pilot Life) for Summary Judgment, or alternatively for Partial Summary Judgment.

Everate W. Dedeaux (Dedeaux), the plaintiff herein, seeks recovery from Pilot Life on three counts: tortious breach of contract; breach of fiduciary relationship; and fraud in the inducement. Dedeaux is 48 years old and has a tenth grade education. In 1960, he became employed by what is now known as Entex. He was insured for disability by Pilot Life through a group disability policy issued to Entex. The policy provided for benefits amounting to $463.63 per month should disability occur. On March 26, 1975, Dedeaux became permanently and totally disabled while attempting to lift an air conditioner. Dedeaux's claim was filed on November 5, 1975. He received his first payment of $463.63 in January, 1976. In June, 1976, Pilot Life reduced Dedeaux's benefits to $154.54 per month by offsetting his children's Social Security benefits. Dedeaux claims he was not told this would be done when he took the policy. On November 10, 1977, Pilot Life issued a letter terminating his bene-

fits. Pilot Life's underwriter wrote Pilot Life, stating that he did not believe benefits could be terminated on December 19, 1977. Dedeaux retained counsel and threatened legal action on March 9, 1978. His benefits were reinstated March 24, 1978. On March 14, 1980, after an independent medical evaluation which Pilot Life's claims supervisor believed adequate to confirm total disability, Dedeaux's benefits were once more terminated. The instant action was filed May 29, 1980.

Pilot Life claims that the group disability policy issued to Entex is maintained pursuant to the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 *et seq.* and that Dedeaux's cause of action is preempted thereby.

This Court disagrees with Pilot Life's contention. Dedeaux could have elected to pursue ERISA remedies; however, he chose state insurance remedies. This is permissible. *Anderson v. Connecticut General Life Insurance Co.* No. J80-0136(R) (S.D. Miss. June 21, 1981); *Eversole v. Metropolitan Life Insurance Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980). In view of this, Pilot Life's Motion for Summary Judgment should be, and hereby is, denied.

Further, this Court is of the opinion that there are material issues of fact relevant to Dedeaux's remaining two counts, such as whether Dedeaux was told that his benefits would be set-off by his or his children's Social Security benefits. Since this and other factual questions remain, Pilot Life's Motion for Partial Summary Judgment should be, and hereby is, denied.

An order in accordance with this Court's foregoing opinion shall be provided as set forth in the Local Rules.

This the 29th day of September, 1983.

/s/ Dan M. Russell, Jr.
United States District Judge

Gulfport, Mississippi

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

No. S80-0467

EVERATE W. DEDEAUX,
Plaintiff

vs.

PILOT LIFE INSURANCE COMPANY
and ENTEX, INC.,
Defendants

[Filed May 24, 1982]

FINAL JUDGMENT

This cause came on for hearing on the Motion for Summary Judgment by the Defendant, Entex, Inc., on May 17, 1982. For the reasons set forth in this Court's Memorandum Opinion, this Court is of the opinion that the Motion for Summary Judgment by Entex, Inc. should be granted.

It is therefore ordered, adjudged and decreed that final judgment be entered in this cause for the Defendant, Entex, Inc., and against the Plaintiff, Everate W. Dedeaux, with all costs herein assessed to Plaintiff.

SO ORDERED, ADJUDGED AND DECREED, this the 21st day of May, 1982.

/s/ Dan M. Russell, Jr.
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

No. S80-0467

EVERATE W. DEDEAUX,
Plaintiff

vs.

PILOT LIFE INSURANCE COMPANY
and ENTEX, INC.,
Defendants

MEMORANDUM OPINION

This cause came on for hearing on the 17th day of May, 1982, on the Motion for Summary Judgment by Entex, Inc. In support of the Motion for Summary Judgment, Entex, Inc. relied on the following:

1. Answer of Pilot Life Insurance Company to Interrogatories Propounded by Plaintiff;

2. Plaintiff's Answers to Interrogatories Propounded by the Defendant, Pilot Life Insurance Company;

3. Plaintiff's Answers to Interrogatories Propounded by the Defendant, Entex, Inc.;

4. Response of Defendant Entex, Inc. to Interrogatories Propounded by the Plaintiff;

5. The Depositions of Everate W. Dedeaux, Plaintiff and John Mobley, Virginia Blakley and David Mitchell, representatives of Pilot Life Insurance Company;

6. Affidavit of R. L. Massingill;

7. Request for Admission of Documents to Pilot Life Insurance Company Propounded by Entex, Inc., and the Response thereto.

In opposition to the Motion for Summary Judgment, Plaintiff relied on a Memorandum from Graham Blanton to John Mobley of Pilot Life, dated March 29, 1978, and an opinion letter by Bruini, Grantham, Grower & Hewes to Mr. Tom Burke of Entex, Inc., dated March 17, 1978, neither of which were accompanied by affidavit or otherwise a part of the court file.

The foregoing pleadings, discovery, affidavits, correspondence, and memorandum establish the following undisputed facts.

Everate Dedeaux began his employment with United Gas, Inc. in 1960. His job duties included driving a truck and repairing gas meters. On March 27, 1969, Everate Dedeaux enrolled in the United Gas, Inc. Employee Long-Term Disability Program, which at that time was offered by Aetna Life and Casualty Company. United Gas, Inc. maintained long-term disability coverage with Aetna Life and Casualty until September 1, 1973, at which time it purchased a group long-term disability policy from Pilot Life Insurance Company. Under the group policy with Pilot Life, United Gas, Inc. matched its employees' contributions of insurance premium and forwarded the premium to Pilot Life. Shortly after the changeover from coverage with Aetna to coverage with Pilot Life, Everate Dedeaux and all other Entex, Inc. employees were provided with a Pilot Life Group Insurance Booklet-Certificate which explained in detail the long-term disability benefits offered by Pilot Life under its policy.

On page 7 of the group insurance booklet-certificate which was provided to Everate Dedeaux, it was explained to Dedeaux and other Entex employees that they would be entitled to long-term disability benefits from Pilot Life:

(a) During the first twenty-four months of any one period of total disability, only if they were continuously and completely prevented by injury or sickness from performing each and every duty of their occupation; and

(b) After that twenty-four month period, only if they were continuously and completely prevented by injury or sickness from engaging in any and every occupation or employment for which they were reasonably fitted by education, training or experience.

On March 28, 1974, the name of "United Gas, Inc." was changed to "Entex, Inc.". Accordingly, a rider was issued on the Pilot Life Disability Policy wherein the name of the policy holder was changed from "United Gas, Inc." to "Entex, Inc."

On March 26, 1975, Everate Dedeaux injured his back by loading an air conditioner onto an Entex truck. He continued to work for several weeks thereafter, but on May 23, 1975, Dedeaux was hospitalized for treatment of his back injury. Under the Entex, Inc. salary continuation plan, Mr. Dedeaux was paid his full salary for the period from May 21, 1975 to September 4, 1975. Mr. Dedeaux returned to work for a short period after September 4, 1975, but on October 9, 1975, he was again hospitalized as a result of his back injury. On October 14, 1975, Dedeaux underwent a lumbar laminectomy and diskectomy and remained in the hospital until October 22, 1975. Under the Entex, Inc. salary continuation plan, Dedeaux was paid his full salary from October 10, 1975, through December 23, 1975, at which time he was to begin receiving long-term disability (LTD) benefits from Pilot Life.

While Dedeaux was recuperating at his home from his back surgery, James Ward of Entex delivered the Pilot Life LTD claim forms to Mr. Dedeaux, and assisted him in filling out these forms. After the forms were com-

pleted, Entex, Inc. forwarded the forms to Pilot Life for payment. Based on the information supplied by Entex, Inc., Pilot Life determined that Mr. Dedeaux would be eligible for disability benefits. Pilot Life advised Homer Robinson, manager of benefits for Entex, that Mr. Dedeaux's first payment would be due on January 24, 1975.

Pilot Life continued to pay long-term disability benefits to Dedeaux for a two-year period from December 23, 1975, until December 23, 1977. However, on November 10, 1977, J. E. Mobley of Pilot Life, advised John Kelly of Entex by letter that Mr. Dedeaux would not be eligible for disability benefits after December 24, 1977, because Dedeaux was not disabled from engaging in any occupation for which he was reasonably fitted by education, training, or experience.

Following receipt of the letter from Mobley, John Kelly and R. L. Massingill of Entex contacted Graham Blanton, group regional director for Pilot Life. Kelly and Massingill advised Graham Blanton that "it was their feeling that there is no way that (Dedeaux) can work and the fact that he is still drawing Social Security puts [Pilot Life] in a precarious position . . ." Also, R. L. Massingill of Entex advised Blanton that Pilot Life should "review the file . . . and give further consideration for payment." Graham Blanton advised John Mobley of these conversations with Massingill and Kelly of Entex by letter dated November 30, 1977.

Following receipt of the November 30 letter from Graham Blanton, John Mobley spoke by phone with Blanton. In this phone conversation Blanton reiterated that Pilot Life was "hard pressed" to cease benefits since Mr. Dedeaux was receiving Social Security benefits. Mobley followed up this phone conversation with a letter to Graham Blanton dated December 9. 1977, wherein Mobley advised Graham Blanton that Pilot Life had determined that "Mr. Dedeaux is not going to be dis-

abled to the extent required by the Policy language," and reaffirmed Pilot Life's intent to cease benefits to Mr. Dedeaux.

In response to this letter, Graham Blanton wrote John Mobley on December 19, 1977. In this letter, Blanton advised Mobley that:

> . . . *following my meeting with Tom Burke, the personnel director, and John Kelly of Entex . . . I don't see how we can justify terminating this man's benefits based on the information I received today.* However, Entex is going to have him examined by their specialist who handles Workmen's Compensation cases in Jackson, Mississippi . . . . They will try to do this as soon as possible. *In the meantime, they would like for us to continue payment.* (Emphasis supplied)
>
> Their regional personnel manager in Jackson has investigated this claim further and since the man is a laborer and can do no lifting or bending, I don't see where he can return to work. They went through the procedures of seeing if he could work as a warehouseman of clerk, and the man does not have the education or experience for this type of job.
>
> We will . . . forward the results of the additional physical examination as soon as it is received, *and in the meantime, please continue payment.* (Emphasis supplied)

In an effort to assist Mr. Dedeaux in obtaining extended disability benefits, R. L. Massingill of Entex authorized Dr. Buford Yerger of the Jackson Bone and Joint Clinic to examine Mr. Dedeaux to determine whether or not he was still disabled. A report was prepared by Dr. Yerger following his examination, and R. L. Massingill forwarded this report to Pilot Life, together with a Proof of Extended Disability Form. Based on Dr. Yerger's medical report, Pilot Life issued

a disability check to Mr. Dedeaux for the period January 24 to February 24, 1978. However, in the same letter in which this disability check was enclosed, J. E. Mobley of Pilot Life advised John Kelly of Entex that Pilot Life had determined Dedeaux to be ineligible for future benefits because Pilot Life's medical department had evaluated Mr. Dedeaux's file and determined that Mr. Dedeaux "was not disabled from performing any occupation for which he was reasonably fitted by education, training or experience."

On March 9, 1978, Herbert Stelly, an attorney in Gulfport, wrote R. L. Massingill and informed him he would file suit on behalf of Dedeaux within ten days if Pilot Life did not reconsider its decision to discontinue Mr. Dedeaux's disability benefits. Massingill forwarded Mr. Stelly's letter to Pilot Life on March 10, 1978. Following receipt of Herbert Stelly's letter, John Mobley discussed Dedeaux's claim with Pilot Life's staff counsel, David Mitchell. Mitchell advised Mobley that it was his opinion that based on Mississippi law, Pilot Life could not defend its actions in terminating Mr. Dedeaux's benefits. Following this conversation between John Mobley and David Mitchell, Pilot Life decided to reinstate Mr. Dedeaux's benefits.

Mr. Stelly was advised that Pilot Life was reinstating Mr. Dedeaux's benefits by letter dated March 24, 1978. In this letter, Pilot Life enclosed disability checks to Mr. Dedeaux for the period February 24, 1978, to March 24, 1978, and advised Mr. Stelly that the next check would be due and payable on April 24, 1978. By letter dated May 4, 1978, J. E. Mobley of Pilot Life asked Herbert Stelly to provide him with additional medical substantiation of Mr. Dedeaux's continuing disability. Pursuant to that request, Mr. Stelly forwarded directly to Pilot Life Supplementary Proof of Extended Disability on May 22, 1978. Pilot Life continued Mr. Dedeaux's LTD benefits for a year thereafter.

In May of 1979, Virginia Blakley, claim supervisor for Pilot Life, assumed full responsibility for the Dedeaux file. On May 15, 1979, Virginia Blakley of Pilot Life wrote John Kelly of Entex and advised him that Pilot Life would need up-to-date medical substantiation in order to continue Mr. Dedeaux's benefits. Entex obtained the necessary information from Dedeaux and forwarded the claims forms and updated medical information to Pilot Life on May 23, 1979. Following receipt of this information, Virginia Blakley requested that Pilot Life's medical staff review the information to determine if Mr. Dedeaux was totally disabled from performing "any occupation." Pilot Life's medical staff suggested that Mr. Dedeaux undergo an independent medical examination. Accordingly, Virginia Blakley, on behalf of Pilot Life, requested that Mr. Dedeaux undergo an independent medical examination by Dr. Thomas F. Hewes in Gulfport, Mississippi. Dedeaux agreed to this medical examination but did not show up for his appointment with Dr. Hewes. Subsequently, Mr. Dedeaux underwent an independent medical examination by Dr. William C. Hopper, Jr. Dr. Hopper submitted his medical report to Pilot Life following his examination of Mr. Dedeaux. In this medical report, Dr. Hopper recommended that Mr. Dedeaux undergo further examination by Dr. Henry LaRocca in New Orleans.

After receiving Dr. Hopper's report, Pilot Life concluded that Mr. Dedeaux was no longer entitled to benefits. By letter dated March 14, 1980, Virginia Blakley of Pilot Life advised Herbert Stelly that Mr. Dedeaux's benefits would be terminated as of March 24, 1980, because the "most current medical report received following Mr. Dedeaux's medical examination does not show him to be totally disabled from performing any occupation." She further advised Mr. Stelly that Pilot Life would refer Mr. Dedeaux to Dr. Henry LaRocca in New Orleans for further evaluation if it was felt that Mr.

Dedeaux continued to be totally disabled. She also advised Mr. Stelly that Pilot Life was closing its file on Mr. Dedeaux. After this suit was filed on May 30, 1980, Pilot Life reinstated Everate Dedeaux's disability benefits.

On March 20, 1981, Mr. Dedeaux gave his deposition. The following facts were established by admissions of Mr. Dedeaux in his deposition: He knew that his disability insurance was with Pilot Life, and not Entex. He received all of his disability checks from Pilot Life, and not Entex. He was looking to Pilot Life and not Entex, to pay on his disability claims. He made no claim that Entex was responsible for his claim being denied on his disability payments, and he was not claiming that Entex made the decision to deny his claim. He admitted that Entex had never taken the position that he was not disabled, and that as far as he knew, Entex did whatever it could to get his disability payments from Pilot Life. He admitted that all of the information provided by Entex to Pilot Life in the processing of the disability claim was accurate, and that he was not making any complaint against Entex about the manner in which it assisted him in filling out his claims forms, or in providing him with whatever information he needed to file his claims. He made no claims that Entex was intending to mislead him when explaining the Pilot Life disability program to him. He thought Entex honestly thought he would receive long-term disability benefits as long as he was disabled. Finally, he admitted that Entex never made any false written statements to him in connection with the long-term disability program.

CONCLUSION OF LAW

Based on the above undisputed facts and admissions by Mr. Dedeaux, this Court is of the opinion that there is no genuine issue as to any material fact in this cause, and that Entex, Inc. is entitled to a judgment as a matter of

law. In Count I of the Complaint, Mr. Dedeaux alleges that Pilot Life and Entex tortiously breached their contract with him by refusing to pay his disability claims.

Entex Interrogatory No. 5, and Plaintiff's response thereto, is set forth below:

> *INTERROGATORY NO. 5*: Upon what facts do you base your contention that Entex, Inc. was obligated to make disability payments to Plaintiff?
>
> *ANSWER*: Entex, Inc. is the agent of the Defendant insurance company and has a mutual obligation to the Plaintiff.

In his deposition, Plaintiff admitted that he was looking to Pilot Life, and not Entex, to pay his disability claim. He admitted that he knew that the long term disability policy was issued by Pilot Life, not Entex. He admitted that he received all of his disability checks from Pilot Life, not Entex. From March 1978, until suit was filed, Plaintiff's attorney communicated directly with Pilot Life in his efforts to obtain disability benefits for Plaintiff. The Plaintiff also admitted in his deposition that Entex, Inc. did not make the decision to deny his claim, and that Entex, Inc. did what it could to obtain disability benefits for him.

Notwithstanding the above facts and admissions by Dedeaux, he contends that Entex, Inc. is liable for breach of contract on the legal theory that Entex, Inc., as agent, is vicariously liable for the breach of contract by Pilot Life, its disclosed principal. Of course, this is not the law. An agent does not incur any liability when its disclosed principal breaches a contract with a third party. *Ketcham v. Mississippi Outdoor Displays*, 33 So.2d 300 (Miss. 1948); *Chipman v. Lollar*, 304 F.Supp. 440 (N.D. Miss. 1970); *Cone Mills Corporation v. Hurdle*, 369 F. Supp. 426 (N.D. Miss. 1974).

Under Count II of the Plaintiff's Complaint, Plaintiff alleges that he is entitled to recovery from Entex, Inc.

and Pilot Life because said Defendants allegedly breached their fiduciary duties to Plaintiff. However, in Mr. Dedeaux's deposition, he admitted that he had no complaint about the manner in which Entex, Inc. assisted him in processing his claims. He admitted that all of the information provided by Entex to Pilot Life in the processing of his disability claim was accurate. He admitted that he was not making any complaint whatever against Entex in the manner of their assisting him in processing his disability claim. He admitted that Entex had done all it could to assist him in receiving disability payments. He admitted that Entex, Inc. had never taken the position that he was not disabled. He denied that Entex was responsible for the denial of his LTD claim, and denied that Entex made the decision to deny the claim.

Counsel for Plaintiff claims that the presence in Dedeaux's claim file of an opinion letter from Entex's counsel to Entex raises a suspicion that Entex actively participated in the claims handling process. However, there is no proof that Entex knowingly provided this opinion letter to Pilot Life's claims personnel. In addition, the opinion letter and deposition testimony of Pilot Life's claims supervisor establishes that the opinion letter had no relevance to Mr. Dedeaux's disability claim, and formed no basis for Pilot Life's decision to terminate Mr. Dedeaux's disability benefits. Plaintiff's speculations and suspicions of the motives and conduct of Entex is not sufficient to raise a genuine issue of a material fact which would entitle Plaintiff to a trial under Count II of his Complaint. The admissions by Plaintiff in his deposition and the other undisputed facts in this case clearly establishes that Entex, Inc. went above and beyond the call of duty in its effort to assist Mr. Dedeaux in receiving disability benefits from Pilot Life. Clearly, Entex breached no fiduciary duty to the Plaintiff.

In Count III of the Complaint, Dedeaux alleged that the Defendants made false oral and written representa-

tions to him concerning the LTD policy and benefits. Dedeaux's claims of false written misrepresentations against Entex are quickly disposed of by his admission in his deposition that Entex had not made any false written statements to him.

Regarding Dedeaux's claims of oral misrepresentations by Entex, in order to recover, Dedeaux must establish (1) a representation, (2) its falsity, (3) its materiality, (4) the speaker's knowledge of its falsity or ignorance of its truth, (5) the speaker's intent that it should be acted upon by hearer in a reasonably contemplated manner, (6) the hearer's ignorance of its falsity, (7) the hearer's reliance on its truth, (8) the hearer's right to rely thereon, (9) and hearer's consequent and proximate injury. *Anderson Dunham, Inc. v. Aiken*, 133 So.2d 527 (Miss. 1961).

As stated above, Dedeaux must first establish that Entex made "a representation" to him. The "representation" charged to Entex by Dedeaux is the alleged statement by Entex to Dedeaux that he would receive LTD benefits from Pilot Life should he become "disabled" in the future. Assuming that this statement was made by Entex to Dedeaux, it was not a "representation" which could constitute an element of fraud. As stated by the Mississippi Supreme Court in *Credit Industrial Co. v. Adams County Lbr. & Sup. Co.*, 60 So.2d 790 (Miss. 1952):

> It is a general rule that fraud cannot be predicated upon statements which are promissory in their nature when made and which relate to future actions or conduct, upon the mere failure to perform a promise—nonperformance of a contractual obligation —or upon failure to fulfill an agreement to do something at a future time. . . The reason for the rule, as stated by the court in *Salitan v. Horn*, supra, are *'that a mere promise to perform an act in the future is not, in a legal sense, a representation, and that a mere failure to perform it does not change its character.* (Emphasis added)

60 So.2d 794.

Therefore, since there was no "representation" made by Entex which could constitute an element of fraud, no finding of fraud can be made based on the undisputed facts. In addition to the fact that there was no actionable "representation," the statements attributed by Dedeaux to Entex were not *false*. Dedeaux claims that Entex made false statements to him when Entex told him that Pilot Life would pay him LTD benefits as long as he was disabled. Even if these statements were made to Dedeaux by Entex, *such statements were not false*. It is undisputed that Pilot Life was to pay LTD benefits to Dedeaux as long as he was "disabled". Pilot Life paid benefits to Dedeaux for the twenty-six months period from December, 1975, until February, 1978, then terminated his benefits when it determined that Dedeaux was not "disabled," as that word was defined in the Pilot Life policy. Payments were then reinstated by Pilot Life and continued from March 1978 until March 1980, at which time Pilot Life again determined that Dedeaux was not "disabled." Dedeaux disagrees with Pilot Life's conclusion that he was not "disabled." However, it is for this Court to decide whether Dedeaux or Pilot Life was right. But that does not mean that the alleged statement by Entex to Dedeaux that he would receive LTD benefits as long as he was "disabled" was a *false* statement.

In addition, to establish fraud, Dedeaux must also prove that Entex intended to deceive him by such false representation. However, Dedeaux has admitted in his deposition that Entex was not intending to deceive him when it told him he would receive LTD benefits as long as he was "disabled." Therefore, since Dedeaux has admitted that there was no intent to deceive by Entex, there can be no fraud claim against Entex.

Finally, in order to establish a fraud claim against Entex, Dedeaux must establish that he relied on statements by Entex to his detriment, and suffered damage as a proximate result of his reliance. The undisputed proof shows that there was no detrimental reliance by Dedeaux. Dedeaux enrolled in the Entex LTD benefit program in 1969. Dedeaux charges that false statements were made to him by James Ward of Entex *after* his injury in March of 1975 when Ward allegedly told Dedeaux that he would receive LTD benefits as long as he was "disabled." Of course, when these alleged "false statements" were made, Dedeaux had been enrolled in the LTD program for six years and had already been injured. There is no proof that Dedeaux relied on "false statements" of Entex in enrolling in the Entex LTD benefit program. Therefore, there was no detrimental reliance by Dedeaux, and another essential element of fraud is lacking.

Therefore, for the above reasons, this Court is of the opinion that there is no genuine issue as to any material fact in this cause, and that Entex, Inc. is entitled to judgment as a matter of law under Fed. R. Civ. P. 56. A final judgment in favor of Entex, Inc. shall be entered in accordance with this Memorandum Opinion, with all costs incurred by Entex, Inc. herein taxed and assessed to Plaintiff.

/s/ Dan M. Russell, Jr.
United States District Judge

May 21, 1982

STATUTORY PROVISIONS

Employee Retirement Income Security Act of 1974, as amended.

1. Section 409, 29 U.S.C. § 1109 (1982). Liability for Breach of Fiduciary Duty.

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 411 of this Act.

(b) No fiduciary shall be liable with respect to a breach of fiduciary duty under this title if such breach was committed before he became a fiduciary or after he ceased to be a fiduciary.

2. Section 502, 29 U.S.C. § 1132 (1982). Civil Enforcement.

(a) A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of [section] 105(c);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (i).

(b)(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1954 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary

shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515.

(c) Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(d)(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpoena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the ad-

ministrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e)(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) The district courts of the United States shall have jurisdiction, without regard to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g)(1) In any action under this title by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section

515 in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1954.

(h) A copy of the complaint in any action under this title by participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Sec-

retary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) In the case of a transaction prohibited by section 406 by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved (as defined in section 4975(f)(4) of the Internal Revenue Code of 1954); except that if the transaction is not corrected (in such manner as the Secretary shall prescribe by regulation, which regulations shall be consistent with section 4975(f)(5) of such Code) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code.

(j) In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

3. Section 503, 29 U.S.C. § 1133 (1982). Claims Procedure.

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

4. Section 514, 29 U.S.C. § 1144 (1982). Effect on Other Laws.

(a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for

the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act.

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b)) or any rule or regulation issued under such law.

McCARRAN-FERGUSON ACT

Section 2, 15 U.S.C. § 1012 (1982). Regulation by State Law; Federal Law Relating Specifically to Insurance; Applicability of Certain Federal laws after June 30, 1948.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Regulations promulgated under Section 503 of ERISA, 29 U.S.C. 1133 (1982).

Section 2560.503-1, 29 C.F.R. § 2560.503-1 (1985). Claims Procedure.

(a) *Scope and purpose.*—(1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggregate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) *Obligation to establish a reasonable claims procedure.* Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as required by § 2520.102-3,

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraph (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which denied claims are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (g) and (h) of this section

(but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) *Claims procedure for an insured welfare or pension plan.*—(1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) *Filing of a claim for benefits.* For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one of more States, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(4) For purposes of paragraphs (d) (1), (2), and (3) of this section, a communication shall be deemed to have been brought to the attention of an organizational unit if it is received by any person employed in such unit.

(e) *Notification to claimant of decision.*—(1) If a claim is wholly or partially denied, notice of the decision, meeting the requirements of paragraph (f) of this section, shall be furnished to the claimant within a reasonable period of time after receipt of the claim by the plan.

(2) If notice of the denial of a claim is not furnished in accordance with paragraph (e)(1) of this section within a reasonable period of time, the claim shall be deemed denied and the claimant shall be permitted to proceed to the review stage described in paragraph (g) of this section.

(3) For purposes of paragraph (e)(1) and (2), of this section, a period of time will be deemed to be unreasonable if it exceeds 90 days after receipt of

the claim by the plan, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the final decision.

(f) *Content of notice.* A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant;

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be ob-

tained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In each case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

(3) A plan may establish a limited period within which a claimant must file any request for review of a denied claim. Such time limits must be reasonable and related to the nature of the benefit which is the subject of the claim and to other attendant circumstances. In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim.

(h) *Decision on review.*—(1) (i) A decision by an appropriate named fiduciary shall be made promptly,

and shall not ordinarily be made later than 60 days after the plan's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

(2) If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(3) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

(4) The decision on review shall be furnished to the claimant within the appropriate time described in paragraph (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

(i) *Apprenticeship plans.* This section does not apply to employee benefit plans which provide solely apprenticeship training benefits.

(j) *Qualified Health Maintenance Organizations.* Claims procedures with respect to any benefits provided through membership in a qualified health maintenance organization, as defined in section 1310 (d) of the Public Health Service Act, as amended, 42 U.S.C. § 300e-9(d), shall be deemed to satisfy the requirements of this section with respect to the provision of such benefits to persons who are members of such qualified health maintenance organization, provided those procedures meet the requirements of section 1301 of the Public Health Service Act, as amended 42 U.S.C. § 300e and the regulations thereunder.

OPPOSITION BRIEF

(3)

No. 85-1043

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

PILOT LIFE INSURANCE CO.,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act preempts state common-law claims against an insurer for failure to pay insurance benefits to a beneficiary of an insured plan?

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RESPONDENT'S BRIEF IN OPPOSITION

Respondent, Everate W. Dedeaux, respectfully requests that this Court deny the petition for the writ of certiorari seeking review of the decision of the Court of Appeals for the Fifth Circuit to reverse and remand this case. The opinion is reported at 770 F.2d 1311.

STATEMENT OF THE CASE

Pilot Life Insurance Company ("Pilot") issued a group insurance policy to Entex, Inc. ("Entex") to insure a long-term disability benefits plan provided by Entex to its employees. Respondent was an employee of Entex on March 26, 1975, when he injured his back.

Respondent filed a claim with Pilot for long-term disability benefits, which were paid for two years. Pilot then refused to pay further disability benefits until employees of both Entex and Pilot urged it to do so. A short time later, however, Pilot again attempted to terminate Respondent's benefits which were reinstated only after Respondent hired an attorney and after Pilot's in-house legal counsel informed Pilot that, based on Mississippi law, the termination of benefits could not be defended. Pilot, nevertheless, continued its attempts to terminate Respondent's long-term disability benefits and finally did so in 1980 in spite of an independent medical examination confirming continued total disability at the time.

On May 30, 1980, Respondent filed a Complaint demanding, in pertinent part, actual and punitive damages for Pilot's wrongful refusal to pay the long-term disability benefits. Subsequently, on April 19, 1983, Pilot filed a motion for summary judgment, asserting that the Employee Retirement Income Security Act ("ERISA") preempted Respondent's state law claims. The motion was overruled pursuant to a memorandum opinion signed by the Court on September 29, 1983. Pilot then filed a motion to reconsider this adverse ruling, asserting the same grounds as previously presented. By opinion dated March 19, 1984, the trial court sustained Pilot's motion for reconsideration and granted summary judgment in its favor.

On appeal, the Fifth Circuit reversed the District Court ruling "on the authority of *Metropolitan Life Insurance Co. v. Massachusetts*, —— U.S. ——, 105 S. Ct. 2380, 85 L.Ed.2d 728 (1985), decided after the decision of the District Court." *Dedeaux v. Pilot Life Insurance Co.*, 770 F.2d 1311, 1312 (5th Cir. 1985). The Fifth Circuit noted that the insurer in the *Metropolitan Life* case raised the same arguments Pilot raised in the Fifth Circuit. It concluded that the Supreme Court's unanimous rejection of those arguments clearly and unequivocally repudiated the same arguments Pilot raised on appeal.[1] Having concluded that Pilot's first four arguments for preemption had been decided against it in *Metropolitan Life*, the Fifth Circuit rejected Pilot's argument that Congress could not have intended to permit states to do the same thing as it did in ERISA with the epithet "ipsi dixit." *Dedeaux*, 770 F.2d at 1316. The Fifth Circuit concluded that the proper analysis of whether a particular law is saved from preemption "ends once it is determined that a law falls within the saving clause and is not exempt by the narrow deemer clause." *Id., citing Metropolitan Life*, 105 S. Ct. at 2393. The Fifth Circuit was, thus, left with the unavoidable conclusion that Respondent's common-law causes of action for Pilot's failure to pay disability benefits were not preempted.

REASONS WHY THE WRIT SHOULD BE DENIED

Since the decision of the Fifth Circuit Court of Appeals correctly followed this Court's decision in *Metropolitan Life*, and since this Court settled the question of preemption in that decision, the writ should be denied.

Both Petitioner and *amici* argue that important congressional policy will be thwarted by the Fifth Circuit decision. In doing so, both ignore the careful consideration of congressional policy given by this Court in the *Metropolitan Life* decision. In short, both re-argue what this Court has already clearly decided:

> If a state law "regulates insurance," . . . it is not preempted. Nothing in the language, structure, or

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[1] Pilot argued that national uniformity would be destroyed, that common-law causes of action could not be laws which regulate insurance, that a distinction between plans that are self-insured and those that are insurance-funded would be indefensible, and that only traditional insurance laws were saved from preemption. *Dedeaux*, 770 F.2d at 1314.

legislative history of the Act supports a more narrow reading[2] of the clause, whether it be the Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA, or the insurers' more speculative attempt to read the saving clause out of the statute.

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter. We also are aware that appellants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.

Metropolitan Life, 105 S. Ct. at 2393 (footnote omitted).

The disingenuous argument made by *amici* that a conflict in "approaches" must be resolved by this Court ignores the factual distinction between insured and self-insured plans giving rise to the so-called difference in approaches.[3]

[2] Elsewhere in the opinion, this Court observed that the preemption language of § 514(a) of ERISA is "substantially qualified" by a "broad" and "explicit" limitation in § 514(b)(2)(A). *Metropolitan Life*, 105 S. Ct. at 2385-86, 2389.

[3] The centerpiece of the briefs filed in support of the petition is *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085 (1985). It is used by both the Petitioner and *amici* to manufacture a non-existent conflict of "approaches" between circuits. *Russell*, however, presents an entirely different factual background, as was recognized by the Ninth Circuit at the outset of its opinion: "Neither plan [in *Russell*] involves an insurance policy." *Russell v. Massachusetts Mutual Life Insurance Co.*, 722 F.2d 482, 486 (9th Cir. 1983), *rev'd*, 105 S. Ct. 3085 (1985).

The arguments concerning the effect of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, made by both Petitioner and *amici* also ignore this Court's decision in *Metropolitan Life*. Perhaps more importantly, those arguments ignore § 514(c)(1) as well.[4] That section makes clear that the laws that are saved by § 514(b)(2)(A) include state decisional law.[5] Thus, Respondent's common-law claims for relief based on a breach of duty of an insurer to its beneficiary clearly are covered both by the McCarran-Ferguson Act and by the very explicit ERISA saving clause.

The Fifth Circuit correctly followed this Court's decision in *Metropolitan Life* in holding that Respondent's state law claims against an insurance company for failure to pay benefits were not preempted since the plan in question was insured.

CONCLUSION

For these reasons, the petition for writ of certiorari should be denied.

Respectfully submitted,

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[4] *Amici* does mention that section in footnote 14 but fails to quote it in its appendix of relevant statutory provisions.

[5] For a thorough discussion, see *Eversole v. Metropolitan Life Insurance Co.*, 500 F.Supp. 1162, 1168 (C.D. Cal. 1980), a case with which this Court is familiar, *Metropolitan Life*, 105 S. Ct. at 2390 n.18, but which is wholly ignored by Petitioner and only noted by *amici*.

REPLY BRIEF

No. 85-1043

IN THE
Supreme Court of the United States
OCTOBER TERM, 1985

PILOT LIFE INSURANCE COMPANY,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

REPLY BRIEF FOR PETITIONER

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January 28, 1986

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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REPLY BRIEF FOR PETITIONER

As the Petition demonstrates, the Fifth Circuit's decision undermines Congress' intent to establish uniform Federal standards for fiduciaries in ERISA and effectively nullifies ERISA's civil enforcement provisions. Respondent's opposition essentially ignores these considerations. Instead, Respondent relies on this Court's decision last Term in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), as the sole basis for denying the Petition. This reliance is clearly misplaced—*Metropolitan Life* provides no support for the Fifth Circuit's holding that State common law actions of general

application are "saved" from the broad sweep of ERISA preemption.

Contrary to Respondent's suggestion, this case is *not* controlled by *Metropolitan Life*. There, the Court was confronted with a section of the Massachusetts insurance code that required insurance companies to provide minimum health care benefits in *all* group insurance policies issued in the state, including policies purchased by employee benefit plans. In upholding the statute, the Court held simply that a state statute aimed directly at insurance companies constituted a law regulating insurance and fell within ERISA's insurance saving clause. Although the statute had the effect of indirectly regulating the terms of group insurance policies purchased by employee benefit plans—an area left unregulated by ERISA—such "indirect regulation" was permissible since *only* the insurance company and *not* the employee benefit plan was subject to direct state control.

In sharp contrast, this case involves state common law causes of action that directly encroach on the administration of the employee benefit plan itself. The processing of a claim for benefits under an employee benefit plan is an integral part of the plan's administration and is subject to direct regulation under ERISA. Moreover, in processing claims for benefits, an insurance company acts in place of the plan's trustees and is subject to the same exacting fiduciary standards established by ERISA. *Metropolitan Life* did not involve any similar state intrusion on the plan itself or its administration. Nor did it address state regulation of areas directly covered by ERISA. Indeed, the plain thrust of the Court's decision was that while state insurance statutes which incidentally regulate insured employee benefit plans survive ERISA preemption, laws directly regulating the plan were prohibited. *See* 105 S.Ct. at 2393.

Not only was the issue presented in *Metropolitan Life* separate and distinct from that here involved, but the consequences for employee benefit plan administration are

far different. The Court's decision in *Metropolitan Life* meant simply that "national plans" would face some "disuniformities" if they "enter[ed] into local markets to purchase insurance." 105 S.Ct. at 2393. However, if the decision below is allowed to stand, plan fiduciaries would be subject to widely varying standards of fiduciary conduct, depending on whether plans were insured or uninsured. As demonstrated in the Petition, such a distinction finds no support in ERISA's plain language or legislative history, both of which show Congress' clear intent to establh a single set of fiduciary principles governing insured and uninsured plans alike.

More importantly, the decision below effectively repeals ERISA's comprehensive civil enforcement provisions, which this Court has recognized as an "interlocking, interrelated and interdependent remedial scheme," *Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S.Ct. 3085, 3093 (1985). If the state contract and tort claims here involved are available, fiduciary claims would no longer be the exclusive province of the Federal courts. Rather, they would revert to the jurisdiction of state courts where they would be subject to fifty varying sets of substantive and procedural rules. Such claims, as in this case, would be tried to a jury rather than a judge, punitive and consequential damages would be available and an entirely different standard of review would apply. This wholesale displacement of ERISA's remedial scheme was neither at issue in *Metropolitan Life*, nor intended by Congress.

Finally, unlike *Metropolitan Life*, this case involves state common law claims of general application, not a state insurance statute. Respondent can point to nothing in ERISA which provides a basis for saving common law actions of *general application* from preemption.[1] To the

[1] Respondent's reliance on ERISA Section 514(c)(1), which defines the term "State law" to include decisional law, is misplaced. That definition apparently applies only to Section 514(a), the preemption provision, which is the only place where the term "State

contrary, as this Court made clear in *Metropolitan Life*, the insurance saving clause "appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the states," and should be read in *pari materia* with that statute. 105 S.Ct. at 2392, n.21. It is well settled that common law claims of general application do not constitute laws regulating insurance under the McCarran-Ferguson Act; by definition, they cannot constitute statutory or administrative schemes of regulation directed at the insurance industry. Similarly, such common law claims cannot be embraced within ERISA's saving clause. Any other construction would effectively repeal ERISA's preemption provision with respect to insured employee benefit plans by excluding every state law of general application—substantive or procedural, without regard to subject matter—from ERISA preemption.

For the foregoing reasons, as well as the grounds advanced in the Petition and by the *amici curiae*, a Writ of Certiorari should issue to review the opinion of the Fifth Circuit.

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law" in that form is used. Moreover, even if the saving clause did embrace State decisional as well as statutory and administrative regulation, there is no basis for contending that it includes decisions of *general* application, not primarily or even incidentally related to insurance.

AMICUS CURIAE

BRIEF

(2)

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3a

QUESTION PRESENTED

Whether the Employee Retirement Income Security Act preempts a plan beneficiary's state common law contract and tort claims against an insurer, acting as an ERISA fiduciary, for an alleged mishandling of a benefit claim?

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BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

This brief is filed on behalf of the American Council of Life Insurance and the Health Insurance Association of America, as amici curiae, in support of the petition for certiorari.[1]

INTERESTS OF THE AMICI

The American Council of Life Insurance ("Council") is the largest life insurance trade association in the United States, representing the interests of 627 member life insurance companies including most of the major life insurers in the country. The Council's members currently hold ninety-five percent of the life insurance in force in legal reserve life insurance companies in the United States. The Health Insurance Association of America ("HIAA") represents the interests of 327 member companies which write over eighty-five percent of

[1] Consent from counsel for both parties has been filed with the Clerk of this Court.

the health insurance written by insurance companies in the United States. The combined memberships of the HIAA and the Council represent over ninety percent of the health insurance written by insurance companies in the United States.

The legal and practical consequences of the Fifth Circuit's opinion below, and the substantial confusion among the lower federal courts concerning the issue presented by this case, are matters of grave concern to the members of the Council and the HIAA. Many members of the Council and the HIAA provide group insurance policies to employers who voluntarily establish employee benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA" or the "Act"), 29 U.S.C. §§ 1001 *et seq.* As with any form of insurance, a predictable allocation of risks and costs, based upon historical patterns of claim payments, is essential to the financial integrity of a finite fund subject to partial liquidation upon the occurrence of events, such as illness or disability. By subjecting insurers which undertake ERISA fiduciary responsibilities to suit under state common laws, in addition to or in lieu of ERISA, for alleged improper handling of benefit claims, the decision below drastically enlarges the risk of such insurers to the varying, and often inconsistent, standards of conduct imposed by state common laws.

The adjudication of benefit claims based upon diverse state common laws will inevitably result in the haphazard imposition of liability against insurer-fiduciaries, many of whom operate in many states; and liability for compensatory and punitive damages is unpredictable under state common laws which permit such awards. Thus, as a result of the decision below, members may be unable to provide affordable group policies of insurance to employers who provide benefit plans, or, in certain circumstances, to provide such policies at all due to the increased liabilities associated with them. The Council and the HIAA thus have a direct and immediate interest in the issue presented in this case.

STATUTES INVOLVED

This case involves Section 514 of ERISA, 29 U.S.C. § 1144, and the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, *et seq.* These provisions are set forth in the Appendix, *infra* pp. 1a-2a.

STATEMENT

Pilot Life Insurance Company ("Pilot") issued a group insurance policy to Entex, Inc. ("Entex") to insure a long term disability benefits plan provided by Entex to its employees (the "Plan"). The Plan provides disability benefits to employees who become disabled due to work-related injuries. Specifically, the Plan provides benefits during the first two years of disability if the employee is unable to perform the duties of his or her occupation. Thereafter, benefits are payable only if the employee is disabled from "any and every occupation or employment for which [he or she is] reasonably fitted by education, training or experience." The Plan is a welfare benefit plan subject to ERISA.

The respondent, an employee of Entex, injured his back in a work-related accident in March, 1975. Respondent sought, and Pilot provided, disability benefits for the first two years after respondent's accident. Although disputes arose after the two-year period concerning respondent's continued eligibility for benefits, Pilot paid disability benefits to respondent until March, 1980. At that time, Pilot discontinued respondent's benefits on the basis of a medical report which concluded that respondent was able to perform light or sedentary work.

No internal appeal of Pilot's decision to terminate disability benefits, as required by ERISA, was filed by respondent. Rather, on May 30, 1980, respondent brought a diversity action against Entex and Pilot in the United States District Court for the Southern District of Mississippi. In his complaint, respondent asserted various state

common law causes of action, including breach of contract, breach of fiduciary duty, and fraud. Respondent sought $750,000 in compensatory damages and $500,000 in punitive damages. Respondent did not assert any claim under ERISA.[2]

The Proceedings Below

On May 21, 1982, Pilot moved for summary judgment, asserting, *inter alia*, that ERISA preempted respondent's state law claims relating to Pilot's termination of disability benefits. The district court granted Pilot's motion, holding that Section 514(a) of ERISA preempted respondent's state law causes of action and that ERISA provided the exclusive remedy for such claims.

On appeal, the Fifth Circuit reversed the decision of the district court. The narrow issue on appeal was whether Section 514(b)(2)(A) of ERISA—the so-called "saving" clause—released respondent's state tort and contract claims from preemption. Relying extensively upon *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), the Fifth Circuit held that respondent's state law claims were not preempted because they fell within the saving clause embodied in Section 514(b) of ERISA. The court thus concluded that "state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to, or coequal with any cause of action available under ERISA." 770 F.2d at 1317.

In reaching this conclusion, the court of appeals focused upon one of the arguments advanced by Pilot—namely,

[2] As the Fifth Circuit noted on appeal of this action, "[t]he reason why Dedeaux did not pursue this tack is obvious—Dedeaux sought $500,000 in exemplary damages, but ERISA neither expressly nor implicitly authorizes such an award. *Massachusetts Mut. Life Insurance Co. v. Russell*, —— U.S. ——, 105 S. Ct. 3085, 87 L.Ed.2d 96 (1985)." *Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311, 1313 n.3 (5th Cir. 1985) (citations omitted). Mississippi common law, on the other hand, does permit punitive damages awards in certain circumstances. *Id.*

that ERISA creates a federal statutory cause of action for precisely the type of conduct underlying respondent's state common law claims, thus occupying the field and preempting those claims. Rejecting this argument, the court below looked to ERISA's saving clause and analogous language in the McCarran-Ferguson Act, and stated that the tort and contract claims asserted by respondent under general state law were laws "which regulate[] insurance" in that they affect the relationship between the insurer, the insured, and the plan beneficiaries. On this basis, the court of appeals held that respondent's causes of action based upon state common law were saved from preemption by ERISA's saving clause.

REASONS FOR GRANTING THE WRIT

1. The Conflict in the Approaches of the Courts of Appeals and the Current Confusion among the Federal District Courts Concerning the Preemptive Scope of ERISA Can Only Be Resolved by This Court.

This case presents a frequently recurring and important issue of federal law, which has generated a conflict in approach among the courts of appeals and has resulted in substantial confusion among the federal district courts. The court below concluded that ERISA does not preempt state common law actions, sounding in contract or tort, arising from an alleged improper handling of a claim for benefits under an ERISA-covered benefit plan. The Ninth Circuit, in a factually similar context, has held that ERISA does preempt state contract and tort law actions arising from an alleged mishandling of a benefit claim. *Russell v. Massachusetts Mutual Life Insurance Co.*, 722 F.2d 482 (9th Cir. 1983), *rev'd on other grounds*, 105 S. Ct. 3085 (1985).

The conflict in the approaches of the courts of appeals turns largely upon the interpretation and application of ERISA's preemption clause and the exception embodied in its saving clause for laws "which regulate[] insur-

ance."[3] Without addressing the operation of the saving clause, the Ninth Circuit in *Russell* held, *inter alia*, that ERISA preempts state common law actions arising from the mishandling of benefit claims because such actions "relate to" employee benefit plans within the meaning of Section 514(a) of ERISA. *See* 722 F.2d at 487-88.[4] The Ninth Circuit supported its preemption analysis with strong evidence in ERISA's legislative history that the Act's preemptive reach was intended to be broad. The Ninth Circuit thus held that the state common law actions for, *inter alia*, breach of contract, breach of fiduciary duty, and breach of the covenant of good faith and fair dealing "relate to" an employee benefit plan, and are thus preempted by ERISA.[5]

[3] Section 514(a) of ERISA preempts all state laws that "relate to" employee benefit plans. *See* 29 U.S.C. § 1144(a). Section 514(b) carves out an exception to this broad preemption clause, providing that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." 29 U.S.C. § 1144(b)(2)(A).

[4] The Ninth Circuit in *Russell* also held that ERISA provided a cause of action for plan beneficiaries for breach of fiduciary duty, and that a fiduciary could be held personally liable to the beneficiary for extracontractual and punitive damages. This Court granted certiorari, and reversed that portion of the Ninth Circuit's decision which held that a plan fiduciary could be held personally liable to a beneficiary for extracontractual damages caused by an alleged improper handling of a benefit claim. In reviewing the Ninth Circuit's decision in *Russell*, this Court expressly did not address or decide the preemption issue. *See Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S. Ct. 3085, 3088 n.4 (1985).

[5] *See also Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208 (8th Cir.), *cert. denied*, 454 U.S. 968 and 1084 (1981) (state common law claim for tortious interference with contract preempted by ERISA since such claim relates to the benefit plan and since ERISA governs the conduct underlying the tort claim); *Authier v. Ginsberg*, 757 F.2d 796 (6th Cir.), *cert. denied*, 106 S. Ct. 208 (1985) (state law action by ERISA fiduciary for retaliatory discharge held to be preempted by ERISA); *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320 (2d Cir.), *appeal pending*, 54 U.S.L.W. 3237 (1985) (ERISA preempts state common law claims for, *inter alia*, breach of contract and fraud because they relate to a welfare benefit plan).

Contrary to the approach of the Ninth Circuit in *Russell*, the court below concluded that the sweeping preemption clause of Section 514(a) was inapplicable, finding escape from it in the exceptions embodied in Section 514(b). Thus, the court below achieved a result entirely different from that in *Russell*, holding that state common law causes of action relating to the mishandling of benefit claims are state laws "which regulate[] insurance" within the meaning of ERISA's saving clause. Thus, in a factual context not markedly different from *Russell*, the Fifth Circuit concluded that respondent's claims for breach of contract, breach of fiduciary duty and fraud were not preempted by ERISA.

Mirroring the conflicting approaches of the appellate courts, the federal district courts addressing this issue have shown a lack of unanimity and inconsistent reasoning concerning this recurring subject. Numerous courts have held that state common law claims for, *inter alia*, breach of contract, breach of fiduciary duty, and fraud "relate to" employee benefit plans and thus are preempted by ERISA.[6] Other district courts have held, on the basis of ERISA's saving clause, that similar state law claims are not preempted.[7]

[6] *See, e.g., Light v. Blue Cross and Blue Shield of Alabama*, 616 F. Supp. 558 (S.D. Miss. 1985); *Justice v. Bankers Trust Co.*, 607 F. Supp. 527 (N.D. Ala. 1985); *Hollenbeck v. Falstaff Brewing Corp.*, 605 F. Supp. 421 (E.D. Mo. 1984); *Miller v. Lay Trucking Co.*, 606 F. Supp. 1326 (N.D. Ind. 1985); *Lucash v. Strick Corp.*, 602 F. Supp. 430 (E.D. Pa. 1984), *aff'd mem.*, 760 F.2d 259 (3d Cir. 1985); *Tolson v. Retirement Committee of the Briggs & Stratton Retirement Plan*, 566 F. Supp. 1503 (E.D. Wis. 1983); *Ovitz v. Jefferies & Co.*, 574 F. Supp. 477 (N.D. Ill. 1983); *Ogden v. Michigan Bell Telephone Co.*, 571 F. Supp. 520 (E.D. Mich. 1983); *Maxfield v. Central States, Southeast and Southwest Areas Health, Welfare & Pension Funds*, 559 F. Supp. 158 (N.D. Ill. 1982); *Calhoun v. Falstaff Brewing Corp.*, 478 F. Supp. 357 (E.D. Mo. 1979); *Hoskins v. Retirement Plan of Standard Oil Co.*, No. 78 C 3670, slip op. (N.D. Ill. 1982).

[7] *See, e.g., Kanne v. Connecticut General Life Ins. Co.*, 607 F. Supp. 899 (C.D. Cal. 1985); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980); *McLaughlin v. Connecticut General*

Only this Court can effectively resolve the conflicting approaches taken by the lower federal courts as to ERISA's impact on the continued viability of state common law actions relating to the mishandling of claims for benefits provided under ERISA plans. Without guidance from this Court, the emphatic command of ERISA's preemption provision, and the uniformity of decision it fosters, will be undermined by the encroachment of varying and inconsistent state common law actions upon an area allocated by Congress to federal law. Some courts may permit plan beneficiaries to avoid the substance of ERISA's preemption provision merely by pleading state causes of action and claiming that they are saved from preemption because they "regulate[] insurance." Such an elevation of form over substance would open the doors to state remedies which may be wholly inconsistent with ERISA's remedial scheme.[8] The application of these state law standards and remedies will not only pose serious problems to insurer-fiduciaries seeking to conform their conduct to the dual obligations of federal and state laws, but will fragment ERISA's carefully constructed regulatory and remedial scheme. Such an emasculation of ERISA's uniform standards for the maintenance and administration of employee benefit plans can only thwart, rather than promote, the policies and objectives of the Act.

2. The Decision Below Misapplies This Court's Opinion in *Metropolitan Life Insurance Co. v. Massachusetts.*

In holding that state common law claims for breach of contract, breach of fiduciary duty, and fraud are not preempted by ERISA, the court below relied upon this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985). Contrary to the assertions of the court below, however, nothing in *Metropolitan Life* compels a finding that state common law rules of general application, as opposed to laws which specifically "regulate" insurance, are saved from preemption by ERISA's insurance saving clause.

The narrow issue presented to this Court in *Metropolitan Life* was whether Massachusetts' mandated-benefit law, which required insurers to provide for certain mental health care benefits in insurance policies issued to Massachusetts residents, was a law which "regulates insurance" within the meaning of ERISA's saving clause. Reaffirming its conclusion that ERISA's preemptive scope is broad, the Court stated that all state laws which "relate to" employee benefit plans, like the mandated-benefit law at issue, are preempted unless saved by Section 514(b). In addressing the application of ERISA's saving clause, the Court relied upon the "common-sense view" of the Act's language and upon analogous language in the McCarran-Ferguson Act. Finding that the McCarran-Ferguson Act "strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws 'which regulate insurance,' " *id.* at 2391, the Court concluded that the mandated-benefit law at issue was saved from preemption.

The court below misconstrued this Court's decision in *Metropolitan Life* when it held that state common law claims for breach of contract, breach of fiduciary duty and fraud were saved from preemption by Section 514(b) of ERISA. This Court's decision in *Metropolitan Life* involved only the application of ERISA's saving clause to a state mandated-benefit statute, specifically directed to insurance and insurers.[9] Unlike state statutes regulating

Life Ins. Co., 565 F. Supp. 434 (N.D. Cal. 1983); *Presti v. Connecticut General Life Ins. Co.*, 605 F. Supp. 163 (N.D. Cal 1985).

[8] The potential for circumventing the remedial scheme of ERISA is quite real. By permitting beneficiaries to sue under state common law for redress of conduct expressly regulated by ERISA, the decision below endorses pleading tactics, like those employed by respondent, which are designed to secure awards of extracontractual and punitive damages—awards which are not authorized by ERISA. *See Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S. Ct. 3085.

[9] Many courts have concluded that mandated-benefit laws and laws regulating insurance contracts fall squarely within the saving clause of ERISA. *See, e.g., Wadsworth v. Whaland*, 562 F.2d 70

the content of insurance agreements, however, the instant case involves state common law rules *generally applicable* to the relations of parties to any sort of contract. Such common law rules do not regulate the substantive content of insurance contracts; nor are they peculiarly applicable to the insurer-insured relationship. Thus, *Metropolitan Life*—a case which involved only a statutory provision regulating the content of insurance policies, and not applicable to contracts generally—does not sweep so broadly as to require the survival of the state common law actions at issue here.

This precise issue was not decided by the Court in *Metropolitan Life*, nor was it decided in *Russell.*[10] By granting the Petition, this Court can resolve the issue left open by its earlier decisions and provide a rule of decision to guide the federal courts in the uniform interpretation and application of this important federal statute.

3. The Decision Below Is Inconsistent with the Broad Preemptive Language of ERISA and the Policies Embodied in the Act.

The decision of the court below that state common law contract and tort claims fall outside the preemptive scope of ERISA runs counter to the clear language and the legislative history of the Act. By giving ERISA's exception clause an unduly expansive reading, the decision below effectively circumvents the broad command of Section 514(a) of ERISA, as shown by its legislative history, and contravenes important policies underlying the Act.

(1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978); *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977); *American Progressive Life and Health Ins. Co. v. Corcoran*, 715 F.2d 784 (2d Cir. 1983); *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985).

[10] Moreover, in a related case, the Court expressly declined to pass judgment on whether an employee's state law claims for breach of contract and bad-faith handling of an insurance claim would have been preempted by ERISA. *See Allis-Chalmers Corp. v. Lueck*, 105 S. Ct. 1904, 1916 (1985).

By its clear terms, ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a). Despite this emphatic command, confusion among the lower federal courts concerning ERISA's "virtually unique pre-emption provision," *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n. 26 (1983), has prompted this Court on numerous occasions to review and interpret these critical words. The principles which have emerged from this Court's decisions are clear: ERISA was meant to have a sweeping preemptive reach, and, with several articulated exceptions, to make employee benefit plan regulation a matter of virtually exclusive federal concern. *See Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2389; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). Thus, this Court has declined to interpret Section 514(a) to preempt only state laws dealing specifically with the subject matters covered by ERISA (e.g., reporting, disclosure, fiduciary responsibility), but has held that ERISA "was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2389.

This broad view of ERISA's preemption provision is likewise compelled by the Act's legislative history. In choosing a broad preemption clause as opposed to a narrower one preempting only those aspects of state law that related to the substantive areas covered by ERISA, Congress clearly expressed its intent that ERISA should occupy the field of employee benefits. *See* Hutchinson and Ifshin, "Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974," 46 U. of Chi. L. Rev. 23, 38-43 (1978). Indeed, Senator Jacob Javits, one of the chief architects of ERISA, explained Congress' decision to enact a virtually all-encompassing preemption clause:

> Such a formulation [i.e., one that limited preemption only to areas specifically regulated by ERISA] raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme. . . . [T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.

120 Cong. Rec. 29,942 (1974).[11] Thus, Congress made clear not only its intent to supersede, at the very least, all state laws that fall within ERISA's substantive reach, but also its intent to preempt state laws that more generally apply to employee benefit plans.

Against this background, the collision of the decision below with the legislative intent underlying the Act becomes quite clear. In holding that state common law actions arising from alleged mishandling of benefit claims are not preempted by ERISA, the decision below ignores the well-articulated intent of Congress to create a pervasive federal scheme of employee benefit plan regulation and strikes at important policies firmly embedded in ERISA. Throughout its deliberations, Congress was acutely aware that the establishment of a comprehensive federal regulatory scheme was critical to ensuring the uniform administration and enforcement of ERISA, and that Section 514 played a paramount role in achieving

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[11] *See also* 120 Cong. Rec. 29,197 (1974) (remarks of Representative Dent) (broad federal preemption was designed to eliminate "the threat of conflicting and inconsistent State and local regulation"); 120 Cong. Rec. 29,933 (remarks of Senator Williams) ("the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans").

this uniformity. Indeed, the Senate Committee stated its intent with clarity:

> Except . . . in certain . . . enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluating fiduciary conduct and for creating a single reporting and disclosure system in lieu of burdensome multiple reports.

S. Rep. No. 127, 93d Cong., 1st Sess., *reprinted in* 1974 *U.S. Code Cong. & Ad. News*, 4838, 4871.[12]

The decision below disrupts the system of uniformity which ERISA was enacted to ensure for employee benefit plan regulation. If state common laws which relate to employee benefit plans in general terms, and which purport to govern areas expressly regulated by ERISA in particular, are held to survive preemption, plan fiduciaries will be subjected to the haphazard application of standards and remedies embodied in varying state laws in addition to or in lieu of the standards and remedies established by ERISA. The uncertainty that such a fragmented system would generate is peculiarly disruptive

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[12] *See also* 120 Cong. Rec. 29,942 (1974) (remarks of Senator Javits); 120 Cong. Rec. 29,197 (1974) (remarks of Representative Dent). In a passage especially applicable to this case, the House Committee articulated the importance of uniformity in the application of ERISA's fiduciary standards:

> [A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decision under the same set of facts may differ from state to state. . . . [I]t is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

H.R. Rep. No. 533, 93d Cong., 1st Sess., 12, *reprinted in* 1974 *U.S. Code Cong. & Ad. News*, 4639, 4650.

in the insurance industry, where the assessment of risks and the prediction of liabilities is fundamental to the decision to insure, or to administer, ERISA plans. As Congress surely recognized, the victims of such a fragmented system would be not only employers and insurers who act as ERISA fiduciaries, but also the employees ERISA was enacted to protect. Because the decision below permits the practices of the several states, as reflected in their common laws, to assume a prominence equal, if not superior, to ERISA with respect to the handling of benefit claims, thereby achieving precisely the result Congress carefully sought to avoid when it enacted ERISA, this Court should grant the Petition and clarify the critical statutory and policy issues presented.

4. The Fifth Circuit's Construction of ERISA's Saving Clause Is Inconsistent with the Terms and Legislative History of Both ERISA and the McCarran-Ferguson Act.

Not only does the decision below contravene congressional intent to give ERISA a sweeping preemptive scope, but the decision rests upon a fundamental misinterpretation of the language of ERISA's saving clause. In holding that state common laws of general application are laws "which regulate[] insurance" within the meaning of Section 514(b), the court below gave the saving clause an unduly broad reading—and one which is inconsistent with both ERISA and the McCarran-Ferguson Act.

By its terms, Section 514(b) states that nothing in ERISA "shall be construed to exempt or relieve any person from *any law of any State which regulates insurance.*" 29 U.S.C. § 1144(b)(2)(A) (emphasis added).[13]

[13] This exception is qualified by the "deemer" clause found in Section 514(b)(2)(B), which provides that no employee benefit plan will be deemed to be an insurance company for purposes of any state law which regulates insurance. *See* 29 U.S.C. § 1144(b)(2)(B). Although the deemer clause distinguishes insured and self-insured plans for purposes of laws regulating insurance, the distinction is one without substance when laws of general application are at issue. Unlike state laws regulating insurance, which by operation of the deemer clause apply to insured but not to self-insured plans, state laws of general application which "relate to" employee benefit plans would necessarily be inapplicable to both insured and self-insured plans because of Section 514(a).

Giving these words their common sense meaning, as this Court has done in construing ERISA, it is obvious from the words themselves that Congress intended to bring within their scope state *regulatory* schemes specifically applicable to insurance, and not judicially-created laws of general application.[14]

Moreover, nothing in the legislative history of ERISA suggests that Congress intended to create a more sweeping exception to the broad preemption clause contained in the Act. Indeed, the legislative history suggests the contrary—that the carefully tailored exceptions to Section 514(a) were to be construed narrowly. *See, e.g.,* 120 Cong. Rec. 29,197 (1974) (remarks of Representative Dent) ("narrow exceptions specifically enumerated"); 120 Cong. Rec. 29,933 (remarks of Senator Williams) ("narrow exceptions specified in the bill"). Had Congress intended to create an all-encompassing exception to an otherwise expansive preemptive scheme, this would surely have been stated in the many pages of legislative

[14] *See Northeast Dept. ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 158 n.8 (3d Cir. 1985) (court stated in dicta that "judge-made rules regarding interpretation of insurance contracts are not the kind of state insurance regulations that the Congress intended to preserve"). Indeed, Congress apparently knew the distinction. In the definitional section found in Section 514, Congress expressly defined "State law"—a phrase it did *not* use in the saving clause—as "all laws, decisions, rules, *regulations*, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1) (emphasis added). Congress' use of the phrase "State law" in Section 514(a), but not in Section 514(b)(2)(A), was likely not unintentional. It is entirely consistent with the terms and policies of the Act for Congress to preempt all "State law" relating to benefit plans, including decisional and administrative laws, while saving from preemption only state regulatory laws applicable to insurance.

history which address the breadth of the preemption clause.[15]

The conclusion that ERISA's insurance saving clause is properly limited to state statutory schemes regulating insurance is supported, if not compelled, by the construction given to analogous language in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* The McCarran-Ferguson Act provides in relevant part that "[t]he business of insurance . . . shall be subject to the *laws of the several States which relate to the regulation or taxation of such business*". 15 U.S.C. § 1012 (emphasis added). Because the terms of Section 514(b) of ERISA are strikingly similar to words used by Congress to establish state primacy over insurance regulation in the McCarran-Ferguson Act, ERISA should be read *in pari materia* with the terms of that Act.

While no unanimous approach to the meaning or scope of the saving clause has emerged in the decade of ERISA's existence, a rather uniform interpretation has been provided by courts to similar language in the McCarran-Ferguson Act. Dealing with the meaning of the words "regulating the business of insurance," this Court in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), provided support for the argument that "regulation" of insurance encompasses legislative and administrative actions, and not the application of generally applicable state common law. In that case, the Court stated:

> Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the [McCarran-Ferguson Act] apply. Certainly the fixing of rates is part of this business. . . . The selling and advertising of policies, *FTC v. National Casualty Co.*, 357 U.S. 560 (1958), and the licensing of companies and their agents, *cf. Robertson v. California*, 328 U.S. 440 (1946), are also within the scope of the statute. Congress was concerned with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.' . . . But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. *Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'*

[15] Congress obviously knew how to exempt laws of general application from the preemptive scope of ERISA. In clear contrast to its reference to laws "which regulate[] insurance" in the saving clause, Congress expressly exempted—in Section 514—"any generally applicable criminal law of a State." 29 U.S.C. § 1144(b)(4).

Id. at 459-60 (emphasis added). *See also FTC v. National Casualty Co.*, 357 U.S. 560, 564-65 (1958) (*per curiam*) (in concluding that states had "regulated" insurance by enacting prohibitory legislation authorizing administrative enforcement, the Court declined to decide whether there was any distinction in the McCarran-Ferguson Act between "legislation" and "regulation").[16] Thus, this Court's decisions demonstrate that state laws regulating insurance are precisely that: they are legisla-

[16] The more recent decisions of this Court concerning the scope of the McCarran-Ferguson Act further support the conclusion that "regulation" of the insurance business does not encompass generally applicable state common laws. In *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), and *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, *reh'g denied*, 441 U.S. 917 (1979), the Court articulated three criteria for determining whether a particular activity constitutes the "business of insurance" within the meaning of that Act: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. at 129. State common law rules relating to damages for failure to meet contract obligations cannot properly be deemed the regulation of insurance within the criteria established and applied in *Pireno* and *Royal Drug*.

tive and regulatory exercises of state sovereigns directed to the business of insurance. There is nothing in this Court's decisions suggesting that "regulate" was meant to encompass adjudication by state courts of common laws of general application which only incidentally relate to insurance.[17]

Nothing in the legislative history of the McCarran-Ferguson Act supports the conclusion that "regulate" encompasses adjudication of state common law claims. Indeed, in discussing the proviso to Section 2(b) dealing with federal antitrust laws, Senator Ferguson shed light on the meaning of "regulation":

> Mr. FERGUSON. . . . But insofar as the State is concerned which has specifically legislated on the subject, the three acts [the Sherman, Clayton, and Federal Trade Commission Acts] shall not apply.
>
> Mr. O'MAHONEY. Mr. President, will the Senator yield?
>
> Mr. McCARRAN. I yield.
>
> Mr. O'MAHONEY. I believe the Senator from Michigan went a little further than was his intention when he said that if the States have *legislated* certain things will take place. The bill says if the States have *regulated.*
>
> Mr. FERGUSON. I had reference to *legislation dealing with regulation and taxes.*

91 Cong. Rec. 1443 (1945) (emphasis added). The great care exercised by Congress in discussing the meaning of

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[17] The distinction between laws of general application and laws regulating insurance has been drawn by the lower federal courts interpreting the McCarran-Ferguson Act. *See, e.g., Hart v. Orion Ins. Co.*, 453 F.2d 1358, 1360 (10th Cir. 1971) (arbitration statutes are "laws of general application pertaining to the method of handling contract disputes," and thus do not regulate the business of insurance within the McCarran-Ferguson Act); *Hamilton Life Ins. Co. v. Republic National Life Ins. Co.*, 408 F.2d 606, 611 (2d Cir. 1969) (same).

this critical term is evident from other passages of the legislative history, as for example, where Senator McCarran, the other chief sponsor of the bill, stated:

> . . . the States may, if they see fit to do so, enact *legislation for the purpose of regulation.* If they do enact such *legislation*, to the extent that they *regulate* they will have taken the business of insurance in the respective States out from under the Sherman Anti-trust Act, the Clayton Act and the other acts.

91 Cong. Rec. 1443 (1945) (emphasis added).[18] Thus, throughout its deliberations on the McCarran-Ferguson Act, Congress made abundantly clear its intent that regulation meant the exercise of control by regulatory agencies over insurance, pursuant to state legislation.

Reading the language of the McCarran-Ferguson Act *in pari materia* with ERISA's saving clause reveals the infirmities inherent in the analysis of the court below. The decision below—that state common laws of general applicability are laws "which regulate[] insurance" within the meaning of ERISA when applied to the handling of benefit claims—purports to draw its strength from an analogous statute which, in no uncertain terms, supports a contrary result. Because the meaning and scope of the phrase "regulates insurance" is at the very heart of the instant case, and, indeed, is the key to resolving the conflicts and confusion among the lower federal courts, this Court should review the critical issue here and establish a rule that gives full effect to the terms and intent of ERISA and the important policies embodied in the Act.

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[18] Other similar examples of Congress' intent concerning the meaning of "regulation" abound. *See, e.g.*, 91 Cong. Rec. 1444 (1945) (remarks of Senators McCarran and White); 91 Cong. Rec. 1480-83 (1945); 91 Cong. Rec. 481-82 (remarks of Senator Radcliffe); 91 Cong. Rec. 1087 (remaks of Representative Hancock); 90 Cong. Rec. 6525 (1944) (remarks of Representative Hancock). *See also* Weller, "To Preempt or to Accommodate: The Question of State and Federal Antitrust Laws under the McCarran-Ferguson Act," 9 U. Tol. L. Rev. 421 (1978).

CONCLUSION

For the reasons set forth above and for the additional reasons advanced in the Petition, the writ of certiorari should be granted.

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December, 1985

APPENDIX

Section 514 of the Employee Retirement Income Security Act of 1974 ("ERISA") provides, in pertinent part, that:

> (a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.
>
> * * * *
>
> [(b)](2)(A) Except as provided in paragraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> [(b)(2)](B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts. . . .

29 U.S.C. § 1144.

The McCarran-Ferguson Act provides, in relevant part, that:

> [1011.] Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

[1012.] (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

15 U.S.C. §§ 1011-1012.

SUPPLEMENTAL BRIEF

5

No. 85-1043

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

PILOT LIFE INSURANCE COMPANY,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

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February 12, 1986

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SUPPLEMENTAL BRIEF FOR PETITIONER

Petitioner, Pilot Life Insurance Company, submits this Supplemental Brief to bring the Court's attention to the Fourth Circuit's recent decision in *Powell v. Chesapeake and Potomac Telephone Co. et al.*, No. 85-1072 (4th Cir. Dec. 18, 1985).[1] *Powell* is in direct conflict with the decision below. There, the Fourth Circuit held that ERISA preempts state tort and breach of contract claims brought against an insurance company serving as an employee benefit plan's claims administrator. In so holding, the Court specifically rejected the notion that such state

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[1] The Fourth Circuit opinion is reproduced in full in the Appendix.

actions were excluded from the scope of ERISA preemption as "laws regulating insurance". The resolution of this conflict between the Fourth and Fifth Circuits provides an additional reason for granting certiorari in this case.

In *Powell*, a participant in a self-funded employee benefit plan filed suit against the plan sponsor and an insurance company serving as the plan's claims processing administrator based upon their alleged mishandling of her claim for disability benefits. The complaint asserted several causes of action under ERISA and state law, including intentional infliction of emotional distress, breach of an implied covenant of good faith and fair dealing, breach of contract, and violation of Virginia's Unfair Trade Practices Act. As relief, the plaintiff sought $5 million in compensatory and punitive damages.

Noting the "unparalleled breadth" of ERISA's preemption clause, the Fourth Circuit concluded that plaintiff's state law claims were wholly displaced by the federal scheme. Appendix at SA-4. The Court recognized that ERISA itself imposed extensive duties on plan administrators and established a comprehensive mechanism for criminal and civil enforcement of fiduciary obligations. Thus, "[t]o the extent that ERISA redresses the mishandling of benefit claims or other maladministration of employee benefit plans, it preempts analogous causes of action, whatever their form or label under state law." *Id.* at SA-5. Any contrary rule, the Court observed, "would undermine ERISA's important policy of promoting uniformity in employee benefit laws . . . by creating the potential for conflicting employer obligations and variable standards of recovery." *Id.* at SA-6.

In reaching this conclusion, the Court refused to exempt plaintiff's state law claims from the expansive scope of ERISA preemption merely because processing of her application for benefits had been delegated to an insurance company. Relying upon this Court's dictate in

Metropolitan Life Insurance Co. v. Massachusetts, 105 S. Ct. 3085 (1985), that ERISA's insurance saving clause was co-extensive with the McCarran-Ferguson Act, the Court ruled that only those state laws that actually "regulate the business of insurance" were saved from preemption. Appendix at SA-8. Thus, ERISA, like McCarran-Ferguson, did not "purport to make the States supreme in regulating *all* the activities of insurance companies." *Id.* (emphasis added). Rather, like McCarran-Ferguson, ERISA permitted state regulation only where such activities properly constituted the business of insurance. *Id.* The insurance company in *Powell* stood in place of the plan sponsor, performing purely administrative claims processing activities for the plan. Regulation of such activities, the Court concluded, neither related to the business of insurance, nor was saved from ERISA preemption.[2] *Id.* at SA-8 to 9.

The administration of employee benefit claims by insurance companies, which the Fourth Circuit in *Powell* found to be regulated exclusively by federal law, is precisely the same activity which the Fifth Circuit in *Dedeaux* would subject to the variable and conflicting standards imposed by state law. As a result, Pilot Life and other insurance companies serving as claims administrators in the Fifth Circuit will be exposed to the full panoply of state common law remedies, including punitive and consequential damages; their counterparts in the Fourth Circuit will be regulated by a single federal standard. Moreover, insurance company fiduciaries administering interstate plans will be subject to the sometimes incompatible obligations of state and federal law, which will undermine Congress' efforts to establish uniform fiduciary

[2] The Court also ruled that neither punitive nor consequential damages are available under ERISA. Accordingly, because plaintiff's state causes of action were preempted and her federal remedies did not extend beyond the recovery of benefits due under the plan, which she had already received, her complaint was dismissed. Appendix at SA-9 to 11.

standards in ERISA. Only this Court can resolve the uncertainty generated by these conflicting opinions and properly interpret this important statutory scheme.

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February 12, 1986

SUPPLEMENTAL APPENDIX

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 85-1072

ELEANOR POWELL,
Appellant,

versus

CHESAPEAKE AND POTOMAC TELEPHONE COMPANY OF VIRGINIA; CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a CIGNA COMPANY, and AMERICAN TELEPHONE AND TELEGRAPH, INC., a NEW YORK CORPORATION,
Appellees.

and

AT&T COMMUNICATIONS OF VIRGINIA, INC.,
Defendant.

Appeal from the United States District Court for the Eastern District of Virginia at Alexandria
Albert V. Bryan, Jr., Chief District Judge. (C/A 84-554)

Argued November 8, 1985 Decided December 18, 1985

Before WIDENER and PHILLIPS, Circuit Judges, and HILTON, United States District Judge for the Eastern District of Virginia, sitting by designation.

Diane H. Mahshie (James R. Tate; Tate and Bywater, Ltd. on brief) for appellant; Jeffrey Anne Tatum (Adams, Duque & Hazeltine on brief); Stephen M. Colangelo (Boothe, Prichard & Dudley; Rodney H. Glover; Thomas & Fiske on brief) for Appellees.

PHILLIPS, Circuit Judge:

Eleanor Powell, a former employee of C&P Telephone Company of Virginia (C&P) and a beneficiary under its self-funded employee benefit plan (the Plan), sued that company, its former parent, AT&T, and Connecticut General Life Insurance Company (Connecticut General), the Plan's administrator, for the breach of various fiduciary duties under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, in the handling of her claim for disability benefits.[1] Although she had received all of the benefits to which she was entitled, Powell sought $5 million in extracontractual and punitive damages under ERISA, and also sought to invoke the court's pendent jurisdiction over Virginia state law claims for intentional infliction of emotional distress, breach of an implied covenant of good faith and fair dealing, breach of contract, and violation of Virginia's Unfair Trade Practices Act, Va. Code § 38.1-49, *et seq.* (1950), based on the same alleged misconduct as gave rise to her federal cause of action under ERISA. The district court granted the defendants' motions for summary judgment and dismissed all of Powell's claims. We agree with the district court that Powell's state law claims are preempted by ERISA, and that extracontractual and punitive damages are not, in these circumstances, available under ERISA, and we therefore affirm.

---

[1] Specifically, the complaint alleges that C&P and Connecticut General failed to discharge their fiduciary duties solely in the interest of Plan beneficiaries pursuant to 29 U.S.C. § 1104(a)(1); breached their duties of disclosure under 29 U.S.C. § 1021; and failed to provide Powell with adequate written notice of termination, as required by 29 U.S.C. § 1133(1).

I

Powell received disability benefits under the Plan from February 1978 through May 1983. She complains of constant harassment by C&P and Connecticut General throughout this period, causing her and her son emotional distress and precipitating her divorce. According to Powell, the appellees repeatedly demanded unnecessary medical reports, refused to provide her attorney with copies of her claim file, and unjustifiably withheld benefit payments on two occasions.

Powell's benefits were terminated in June 1983, after she received a substantial Social Security award, which represented monthly benefits retroactive to July 1977. When combined with the Social Security award, Powell's Plan benefits exceeded 50% of her base pay prior to disability, the benefits ceiling under the Plan. Powell refused C&P's request to refund the overpayment.

Thereafter, Powell filed this action and the defendants counterclaimed for a refund of benefits. The counterclaim was nonsuited after Powell's complaint was dismissed, and this appeal followed.

II

A. *Preemption of State Law Claims.*

With certain stated exceptions,[2] ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). "State law" is defined to include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1).

---

[2] The most important of these exceptions allow continued operation of state insurance, banking, and securities laws, 29 U.S.C. § 1144(b)(2)(A), and generally applicable criminal laws, 29 U.S.C. § 1144(b)(4).

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983), the Supreme Court, citing legislative history and referring to the language and structure of the statute, construed the preemption clause in its broadest sense, and held that "[a] law 'relates to' an employee benefit plan . . . if it has a connection with or reference to such a plan." Thus, the scope of § 1144(a) is not limited to state laws "specifically designed to affect employee benefit plans." *Id.* at 98.

The state laws at issue in *Shaw*, the New York Human Rights Law (prohibiting discrimination in employment, including discrimination in employee benefit plans on the basis of pregnancy), and New York's Disability Benefits Law (requiring employers to pay sick-leave benefits to employees unable to work due to pregnancy), "clearly 'relate to'" employee benefit plans. *Id.* at 97. The Court observed, however, that some state actions may affect employee benefits plans in "too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Id.* at 100, n.21. This category includes, for example, state garnishment of a spouse's pension income to enforce alimony and support orders. *Id., citing American Telephone and Telegraph Co. v. Merry*, 592 F.2d 118 (2d Cir. 1979).

In this case, none of the state laws under which Powell claims relief have any intrinsic connection with employee benefit plans. The question is therefore whether state law *claims* which relate to the administration of an ERISA-governed plan, but which arise under general state *laws* which themselves have no impact on employee benefit plans, are within the scope of ERISA preemption. Given the "unparalleled breadth" of the preemption clause, *Holland v. Burlington Industries, Inc.*, No. 84-2241(L), slip op. at 17 (4th Cir. Sept. 3, 1985), and the broad remedial policy of ERISA, we hold that state laws, insofar as they are invoked by beneficiaries claiming relief for injuries arising out of the administration of employee

benefit plans, "relate to" such plans and, absent an applicable exemption, are preempted by ERISA.

The preemption clause effectuates a broad remedial policy to protect the interests of participants in ERISA-governed plans and their beneficiaries "by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). Thus, ERISA imposes extensive duties on plan administrators, 29 U.S.C. §§ 1101-1114, and provides a comprehensive scheme for the criminal and civil enforcement of fiduciary obligations, 29 U.S.C. §§ 1131-1132.[3] To the extent that ERISA redresses the mishandling of benefits claims or other maladministration of employee benefit plans, it preempts analogous causes of action, whatever their form or label under state law. *See Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1215-16 (8th Cir. 1981) ("If

[3] Under 29 U.S.C. § 1132, entitled "Civil enforcement," a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce his rights under the plan, or to clarify his rights to future benefits under the plan, § 1132(a)(1)(B); or, if the plan administrator fails or refuses to comply with a request for certain information, a beneficiary may recover, subject to the court's discretion, up to $100 a day from such failure or refusal, § 1132(a)(1)(A); or, a participant, beneficiary, or fiduciary may bring an action to enjoin administrative acts which violate ERISA or the terms of the plan or to obtain "other appropriate equitable relief" to redress such violations or to enforce provisions of ERISA or the terms of the plan. § 1132(a)(3). A plan may recover from its administrator any losses resulting from the breach of fiduciary duties and may seek "such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary," § 1109(a). Any person who willfully violates the provisions of ERISA may be fined, upon conviction, up to $5,000, or imprisoned up to one year, or both, and in the case of violations by other than an individual, a fine of up to $100,000 may be imposed, § 1131. For other remedies, including those available to the Secretary, see §§ 1132(a)(4), (a)(5), (a)(6), (b); for availability of attorney's fees and costs, see § 1132(g).

Congress has already provided a remedy [under ERISA], . . . the state law is preempted, regardless of whether or not a conflict exists which involves a direct interference by the state law with [ERISA]."). A contrary rule would undermine ERISA's important policy of promoting uniformity in employee benefit laws, reflected in the legislative history, in the Act's declaration of policy, and in the preemption clause itself, by creating the "potential . . . for conflicting employer obligations and variable standards of recovery." *Holland*, No. 84-2241(L), slip op. at 17-18. Accordingly, the state law claims in this case, all of which relate exclusively to alleged breaches of fiduciary responsibility in the administration of C&P's employee benefit plan, "relate to" the plan and, unless an exception applies, are preempted, leaving Powell to such remedies as are available under ERISA.

This analysis comports with several recent Ninth Circuit decisions in which that court concluded that state claims based on the maladministration of employee benefit plans are preempted by ERISA, even where the state statutory and common law under which the claims arise bears no inherent connection with ERISA-governed plans. *See Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1095 (9th Cir. 1985); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1504-05 (9th Cir. 1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356 (9th Cir. 1984); *Russell v. Massachusetts Mutual Life Insurance Co.*, 722 F.2d 482, 487-88 (9th Cir. 1983), *rev'd on other grounds*, —— U.S. ——, 53 U.S.L.W. 4938 (U.S. June 27, 1985). *See also Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320, 327 (2d Cir. 1985).

Powell contends that even if her state law claims are within the scope of ERISA's preemption provision, her claims for breach of an implied covenant of good faith and fair dealing and for violations of the Virginia Unfair Trade Practices Act, both of which purport to impose

duties on insurers,[4] are nevertheless rescued from preemption by an "insurance saving clause," which provides that ERISA does not "exempt or relieve any person from any law of any State which regulates insurance. . . ." 29 U.S.C. § 1144(b)(2)(A). We disagree. The insurance saving clause is limited by the so-called "deemer clause," which provides that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ." 29 U.S.C. § 1144(b)(2)(B). Thus, C&P cannot be deemed to be an insurer or otherwise engaged in the business of insurance by virtue of its sponsorship of the Plan and Powell's claims against C&P under state laws regulating insurance are not exempted from preemption by the insurance saving clause.

Since Connecticut General is not an "employee benefit plan," the deemer clause is inapplicable to it. *See* 29 U.S.C. § 1144(b)(2)(B). Powell contends that as an insurance company, Connecticut General is subject to state laws regulating insurance, including the implied covenant of good faith and fair dealing and the Virginia Unfair Trade Practices Act, and that these claims are therefore

[4] The Virginia Unfair Trade Practices Act constitutes Article 6 of Virginia's Insurance Code and declares as its purpose the regulation of trade practices in the business of insurance. Specifically, Powell alleges in her complaint that the defendants violated § 38.1-52.1 which provides that "[n]o person shall make, issue, [or] circulate . . . any estimate, illustration, circular, statement, sales presentation, omission, or comparison which 1) Misrepresents the benefits, advantages, conditions or terms of any insurance policy."

The implied covenant of good faith arises, in certain circumstances, from the "relationship of confidence and trust . . . between the insurer and the insured which imposes upon the insurer the duty to deal fairly with the insured in the handling and disposition of any claim covered by the policy." *Aetna Casualty & Surety Co. v. Price*, 206 Va. 749, 761, 146 S.E.2d 220, 227-28 (1966).

saved from preemption by the insurance saving clause, § 1144(b)(2)(A).

We read the insurance saving clause, however, to exempt from ERISA's preemptive effect only those state insurance laws that regulate the "business of insurance." Regulation of the "business of insurance" is expressly reserved to the states by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1115,[5] and ERISA's insurance saving clause, which is similarly worded and which reflects the conce~~rns of~~ McCarran-Ferguson, is most reasonably construed to cover the same category of state insurance regulation. *See Metropolitan Life Insurance Co. v. Massachusetts*, —— U.S. ——, 53 U.S.L.W. 4616, 4621 n.21 (U.S. June 3, 1985) ("The ERISA saving clause . . . appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States.").

The primary features of an insurance contract are the spreading and underwriting of a policyholder's risk. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979). In enacting the McCarran-Ferguson Act, "Congress was concerned with the type of state regulation that centers around the contract of insurance . . . ." *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). The Act did not, however, "purport to make the States supreme in regulating all the activities of insurance *companies*; . . . only when they are engaged in the 'business of insurance' does the statute apply." *Id.* at 459-60.

In its role as Plan administrator, Connecticut General neither spreads nor underwrites insurance risks; there is no insurance policy or contract. Rather, Connecticut General provides certain purely administrative claims processing functions pursuant to an administrative services agreement with the Plan's sponsor, C&P.[6] Thus, notwithstanding that Virginia's implied covenant of fair dealing and Unfair Trade Practices Act may in some circumstances reach even the purely administrative activities of insurers,[7] such regulation would not bear upon the "business of insurance" within contemplation of ERISA's insurance saving clause and thus is not saved from preemption by ERISA.

[5] The McCarran-Ferguson Act provides, in pertinent part, that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . ." 15 U.S.C. § 1012(b).

B. *Availability of Extracontractual and Punitive Damages under ERISA*

Having received all of the benefits to which she is entitled, Powell seeks extracontractual and punitive relief under ERISA to compensate her for various alleged physical ailments, the decline of her marriage, her son's emotional distress, and the deterioration of her mental health, on account of the mishandling by C&P and Connecticut General of her disability claim. Powell contends that such extraordinary relief is available under 29 U.S.C. § 1132(a)(3) which authorizes a civil action by a plan beneficiary "(A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) *to obtain other appropriate equitable relief*, (i)

[6] Under the administrative services agreement, Connecticut General agreed, among other things, to provide standard claim forms for the administration of the plan; to determine the propriety of claims in accordance with C&P's claims administration procedures and practices; to issue checks, drawn against C&P's funds, in payment of claims; to prepare monthly and annual reports; and to review each claim that has been denied for compliance with ERISA when the claimant requests such review.

[7] We express no opinion whether such private causes of action, in another context, would be cognizable under Virginia law. It is worth noting, however, that the Virginia Unfair Trade Practices Act also purports to regulate "the business of insurance in accordance with the intent of Congress" as expressed in the McCarran-Ferguson Act. Va. Code § 38.1-49 (1950).

to redress such violations or (ii) to enforce any provisions of [ERISA] or terms of the plan." (Emphasis added.) In *Massachusetts Mutual Life Insurance Co. v. Russell*, —— U.S. ——, 53 U.S.L.W. 4938 (U.S. June 27, 1985), the Supreme Court held that extracontractual and punitive damages are not available to a participant or beneficiary under § 1132(a)(2), which authorizes a civil action by the Secretary or by a plan participant, beneficiary, or fiduciary "for appropriate relief under § 1109," which relates to liability for breach of fiduciary duty. The question whether or to what extent extracontractual and punitive relief is authorized by way of the catchall provision in § 1132(a)(3) for "other appropriate equitable relief" was expressly reserved. *Id.* at 4940 n.5.

Powell urges that notwithstanding the use of the word "equitable" in § 1132(a)(3) and its implications for excluding the damage remedies she seeks, ERISA incorporates the fiduciary standards and principles of trust law, the violation of which, although ordinarily redressed in equity, may nevertheless give rise to monetary damages in appropriate cases. The legislative history supports Powell's theory that Congress intended to import into ERISA principles of trust law, *see* H.R. Rep. No. 533, 93d Cong., 1st Sess. 11 (1973), as does the language of 29 U.S.C. § 1104(a), which expressly incorporates a general "prudent man" standard of care for ERISA fiduciaries.

Powell's argument is self-defeating, however, because even assuming that "other appropriate equitable relief" may, in certain circumstances, include extracontractual or punitive damages, such relief is generally not available in an action by a beneficiary against a trustee for breach of trust. *See* Restatement (Second) of Trusts § 205 (1959) (liability for breach of trust is limited to (a) loss in value of trust estate; (b) profits accrued by trustee; or (c) profits lost to estate); G. Bogert & G.

Bogert, the Law of Trusts & Trustees, § 862 (2d ed. 1982) (trustee is usually charged only with the loss in value of the trust estate although exemplary damages are occasionally awarded in a few states where malice or fraud is involved); A. Scott, The Law of Trusts, § 198.1 (1967) ("where the trustee is not under an immediate and unconditional duty to pay money to the beneficiary, the beneficiary cannot maintain an action at law against him."). Thus, the provision for "other appropriate equitable relief," whatever it embraces, cannot be held to authorize extracontractual or punitive damages for the breach of a plan administrator's fiduciary duties under ERISA.[8]

Accordingly, the district court properly granted the defendants' motions for summary judgment as to Powell's claims for extracontractual and punitive damages under ERISA, and her complaint was properly dismissed.

AFFIRMED.

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[8] We observe that the maladministration alleged by Powell does not rise to a "willfull" violation of ERISA for purposes of the Act's criminal enforcement provision, 29 U.S.C. § 1131.

AMICUS CURIAE

BRIEF

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No. 85-1043

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1985

PILOT LIFE INSURANCE COMPANY, PETITIONER

v.

EVERATE W. DEDEAUX

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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27 pp

QUESTION PRESENTED

Whether Section 514 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. (& Supp. II) 1144, which provides that ERISA preempts state laws relating to employee benefit plans but also provides that ERISA does not preempt state laws that regulate insurance, bars a participant in an employee benefit plan from asserting against an insurance company state common law causes of action alleging improper refusal to pay a claim for benefits.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. Entex, Inc. established a long-term disability plan for its employees by purchasing a group insurance policy from petitioner, which is an insurance company. Under the plan, petitioner is responsible for processing claims for benefits and petitioner alone possesses the discretion and authority to determine who receives disability benefits under the policy (Pet. App. 2a). Because it has "discretionary authority or discretionary control" in the administration of the plan, petitioner is a fiduciary under the Employee Retirement Income Security Act of 1974 (ERISA), § 3(21)(A), 29 U.S.C. 1002(21)(A); see also 29 C.F.R. 2560.503-1(g)(2).[1]

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[1] As a fiduciary, petitioner is subject to ERISA's requirements that fiduciaries must discharge their duties with respect to a plan

Respondent is an employee of Entex who, as a participant in Entex's disability plan, applied for long-term disability benefits following a work-related injury. For two years, petitioner, as claims administrator, paid the benefits. For the next three years, petitioner repeatedly terminated and then reinstated benefits (Pet. App. 2a-3a, 19a-20a, 24a-29a). Following a March 1980 termination, respondent brought suit against petitioner and his employer in federal court. Respondent asserted only state law claims for tortious breach of contract, fraud in the inducement, and breach of fiduciary relationship, and did not assert any claims under ERISA (Pet. App. 19a). Respondent could have asserted a cause of action under Section 502 of ERISA, 29 U.S.C. 1132, alleging that petitioner improperly refused to pay benefits.[2]

The district court, after granting summary judgment to Entex (Pet. App. 21a), initially ruled that respondent's state law claims were not preempted by ERISA and accordingly denied petitioner's motion for partial summary judgment (Pet. App. 19a-20a). On reconsideration the court granted summary judgment to petitioner on the ground that ERISA preempted respondent's state law claims (Pet. App. 13a, 16a-18a).[3]

solely in the interest of plan participants and beneficiaries, for the exclusive purpose of providing benefits to such participants and beneficiaries, and with the care, skill, prudence, and diligence that a prudent man acting in a like capacity and familiar with such matters would use under prevailing circumstances (§ 404(a)(1), 29 U.S.C. 1104(a)(1)).

[2] The court of appeals in this case recognized (Pet. App. 3a n.3) that the availability of punitive damages under state law was the reason respondent chose to pursue state law remedies rather than the remedies provided by ERISA, which may not provide for punitive damage awards to a beneficiary. See *Massachusetts Mutual Life Ins. Co.* v. *Russell*, No. 84-9 (June 27, 1985).

[3] The district court also found that Entex's plan was not established solely to comply with applicable state workmen's compensation or disability insurance laws (Pet. App. 17a-18a & n.1); had this been the case ERISA would not preempt state laws. See generally § 4(b)(3), 29 U.S.C. 1003(b)(3); *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 107-108 (1983).

2. The court of appeals reversed (Pet. App. 1a-11a). It noted (*id.* at 4a) that ERISA's preemption clause (Section 514(a)) broadly provides that the provisions of ERISA "supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" (29 U.S.C. 1144(a)). However, the court also noted (Pet. App. 5a) that ERISA's "saving" clause (Section 514(b)(2)(A)) provides that ERISA does not "exempt or relieve any person from any law of any State which regulates insurance" (29 U.S.C. 1144(b)(2)(A)). The court held that respondent's state law claims were laws which regulate insurance under ERISA's saving clause and therefore were not preempted.

The court of appeals concluded (Pet. App. 7a) that in *Metropolitan Life Ins. Co.* v. *Massachusetts*, No. 84-325 (June 3, 1985), which was decided while the appeal was pending, the Court "clearly and unequivocally repudiated" four of the five arguments petitioner presented in support of its argument that respondent's state law claims were preempted. According to the court, the decision in *Metropolitan Life* required it to reject petitioner's arguments that: (1) Congress's preeminent intent to maintain national uniformity in the maintenance and administration of employee benefit plans would not be served by allowing duplicative, inconsistent, or conflicting state regulations; (2) exceptions to ERISA's broad preemption rule should be construed narrowly; (3) an irrational and indefensible distinction between insured and self-insured plans should not be created; and (4) the saving clause should be construed to save only "traditional" insurance laws from preemption (Pet. App. 5a-6a).

The court of appeals also rejected petitioner's argument that because Congress had proscribed Pilot Life's alleged misconduct and had created an ERISA cause of action to remedy it, duplicative state causes of action should not be permitted. The court concluded (Pet. App. 10a) that the state causes of action respondent invoked affected the insurer-insured relationship and were at the "core" of what courts had determined to be the "business

of insurance" under the McCarran-Ferguson Act, 15 U.S.C. (& Supp. II) 1011 *et seq.*, and therefore were "laws 'which regulate[] insurance'" under ERISA's saving clause. The court of appeals held that state laws proscribing the same conduct as ERISA may provide causes of action "in place of, in addition to, or coequal with any cause of action available under ERISA" and stated that petitioner's concerns over the practical consequences of this result must be addressed to Congress (Pet. App. 11a).

ARGUMENT

The Court should grant the petition for a writ of certiorari because the court of appeals' decision creates troublesome, new, and indeterminate distinctions between insured and uninsured employee benefit plans and because the Court will have to consider the question presented here in deciding *General Motors Corp.* v. *Taylor*, cert. granted, Nos. 85-686 and 85-688 (Feb. 24, 1986). On the merits, while the arguments presented by both sides are not without difficulty, on balance we think Congress did not intend to permit participants in insured benefit plans to pursue state common law causes of action of general applicability.

1. The Court should grant review in this case to resolve an important question of federal law regarding the interpretation of ERISA's saving clause. The question presented in this case is whether ERISA's preemption provision bars employees from asserting against insurance companies serving as administrators of insured employee benefit plans common law causes of action which are not specifically devised to govern the business of insurance. Under the court of appeals' decision, participants in insured plans are not limited to bringing suit under the federal common law of ERISA and are not limited to the remedies available under Section 502 of ERISA, 29 U.S.C. 1132. Instead an employee participating in an insured plan may pursue state common law causes of action and may seek punitive damages from an insurance company administering a benefit plan in any state where such damages are available under common

law rules relating to such general causes of action as fraud, breach of contract, or breach of fiduciary duty. Indeed, as petitioner states (Pet. 11-12), an employee participating in an insured ERISA plan will be able under the court of appeals' decision to pursue whatever remedies state law provides and avoid the procedures provided in ERISA altogether.

The issue in this case is likely to arise whenever there is a claim for benefits from an insured plan administered by the insurance company and state law provides punitive damages or other remedies more advantageous than those provided by ERISA. Because this issue will arise frequently, the courts of appeals will benefit from resolution of the issue presented. In *Pokratz* v. *Jones Dairy Farm*, 771 F.2d 206, 211 (7th Cir. 1985), the court of appeals refused to express its views on whether a plan participant could pursue state law remedies against a plan and its administrator, terming that "a difficult and unresolved question." Similarly, in *Taylor* v. *General Motors Corp.*, 763 F.2d 216, 220 (6th Cir. 1985), cert. granted, Nos. 85-686 and 85-688 (Feb. 24, 1986), the court of appeals "express[ed] no opinion concerning whether Congress intended ERISA to preempt" state common law claims for benefits. Rather, it held that "[i]t is not 'clearly established' that actions for benefits allegedly due under a group insurance policy 'necessarily' arise under federal law simply because the insurance policy is part of an overall benefit plan established pursuant to ERISA," so that the district court had erred in permitting the defendants to remove the case to federal court (763 F.2d at 219).[4]

[4] While there is some confusion in the courts of appeals over whether plan participants may pursue state law remedies, there is at present no clear conflict between this case and the decision of any other court of appeals. The Fourth Circuit's decision in *Powell* v. *Chesapeake & Potomac Tele. Co.*, 780 F.2d 419 (1985), petition for cert. pending, No. 85-1701, cited by petitioner as presenting a conflict (Supp. Br. 1), involved a self-insured plan. While an insurance company adjudicated claims for benefits under the plan, the insurance company had no insurer-insured relationship with claimants.

Moreover, the question presented in this case will be considered by the Court in deciding *Taylor*. In that case General Motors and Metropolitan Life contend (Pet. Br. at 11-30) that a participant's claims against his employer and its insurer for benefits under an ERISA plan must necessarily arise under ERISA, and therefore are subject to removal to federal court, even though the complaint in that case, like the complaint here, contains only state law claims. General Motors and Metropolitan Life argue that "ERISA has supplanted any state law cause of action with a cause of action that is exclusively federal in nature" (*id.* at 11) and therefore that the Fifth Circuit's decision in this case is incorrect (*id.* at 32-42). Because *Taylor* presents other potentially dispositive questions [5] as well as the important question presented by this case, the Court should grant this petition for a writ of certiorari and hear this case in conjunction with *Taylor*.

The court of appeals, noting this Court's admonition that a distinction should be made between the "business of insurance" and the "activities of insurance *companies*" (Supp. Br. App. 5A-8A (emphasis in original)), citing *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 359, 460 (1969)), therefore held that ERISA's saving clause did not apply. Here, in contrast, an insurer-insured relationship exists between petitioner and respondent.

While the district courts have generally agreed with the decision of the court of appeals in this case (see *Lessard* v. *Metropolitan Life Ins. Co.*, 618 F. Supp. 1268, 1272 (D. Me. 1985); *Kanne* v. *Connecticut Gen. Life Ins. Co.*, 607 F. Supp. 899, 905 (C.D. Cal. 1985); *Presti* v. *Connecticut Gen. Life Ins. Co.*, 605 F. Supp. 163, 167 (N.D. Cal. 1985); *McLaughlin* v. *Connecticut Gen. Life Ins. Co.*, 565 F. Supp. 434, 443 (N.D. Cal. 1983); *Eversole* v. *Metropolitan Life Ins. Co.*, 500 F. Supp. 1162, 1168 (C.D. Cal. 1980)), one district court recently held that common law causes of action are not laws that regulate insurance within the meaning of ERISA's saving clause (*Benvenuto* v. *Connecticut Gen. Life Ins. Co.*, No. 84-3601 (D.N.J. Feb. 11, 1986)).

[5] General Motors and Metropolitan Life also argue (Pet. Br. at 42-48) that even if the Fifth Circuit's decision in this case is correct, the Sixth Circuit erred in holding that their case could not be removed to federal court because the plaintiff's claim falls within the district court's original jurisdiction and because it contains one claim that is clearly governed by federal law.

2. The result reached by the court below substantially undercuts several of Congress's goals in structuring and enacting ERISA. As this Court has recognized, Congress included a broad preemption provision in ERISA so that in administering benefit plans employers would not be required to comply with numerous and possibly conflicting state laws (*Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983), quoting *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 503, 523 (1981)): "By establishing benefit plan regulation 'as exclusively a federal concern', * * *, Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees." Although since the *Metropolitan Life* decision any claim based on the need for uniformity is considerably qualified, the result reached by the court of appeals here opens the door to a far greater degree of disuniformity than that envisaged by the Court in *Metropolitan Life*. Under the court of appeals' decision, insurance companies administering insured plans are subject not only to state laws specifically designed to regulate the subject of insurance but also to the varying remedies provided by state laws of general applicability, such as state laws of tort or contract.

In addition, the court below, while acknowledging that remedies against self-insured plans are limited to those specified by ERISA, permitted an indeterminate variety of state law remedies to be invoked against insurance companies administering insured plans. This distinction in the treatment of insured and uninsured employee benefit plans goes well beyond the distinction *Metropolitan Life* acknowledged as a consequence of a state's power to impose provisions on insured plans pursuant to a state's regulation of insurance. The remedies available to plan beneficiaries under ERISA may not include an award of punitive damages. See *Massachusetts Mutual Life Ins. Co.* v. *Russell*, No. 84-9 (June 27, 1985). By contrast, remedies available under state common law, arising out of either tort or contract, may include not only punitive damages, as in this case, but also damages for pain and suffering and other consequential damages.

See, *e.g.*, *Silberg* v. *California Life Ins. Co.*, 11 Cal. 3d 452, 521 P.2d 1103, 113 Cal. Rptr. 711 (1974); *World Ins. Co.* v. *Wright*, 308 So. 2d 612 (Fla. Dist. Ct. App.), cert. denied, 322 So. 2d 913 (Fla. 1975); *Bibeault* v. *Hanover Ins. Co.*, 417 A.2d 313 (R.I. 1980).

Such differences between insured and uninsured plans may well turn out to be far more burdensome and troubling than those flowing out of the relatively focused provisions of state law regulating insurance as such. These further and open-ended differences resulting from the availability of general common law remedies may make funding welfare benefit plans by purchasing insurance relatively expensive compared with self-insuring. We doubt that Congress intended to create this more substantial incentive to self-insure since employees' benefits may be better protected by insured plans.[6] In addition, some employers may find that the purchase of insurance is prohibitively expensive as a result of state-imposed remedies and that self-insurance is not feasible, and therefore not establish welfare benefit plans, ~~as~~ a result clearly contrary to Congress's purposes in enacting ERISA.

Finally, the result reached by the court below permits employee beneficiaries to avoid the carefully constructed administrative claims procedure specified by ERISA. Section 501 (29 U.S.C. 1133) provides employees whose claims have been denied with "a full and fair review by the appropriate named fiduciary of the decision denying the claim." The Department of Labor has interpreted this provision to apply to insured as well as uninsured plans (29 C.F.R. 2560.503-1(c)). However if state common law is not preempted as to insured plans, an employee beneficiary may be permitted to go directly to state court without any effort to utilize the procedures Congress has mandated and the Department has specified in detail. See 29 C.F.R. 2560.503-1.

[6] Indeed one of Congress's stated purposes in enacting ERISA was to "assur[e] the equitable character of such plans and their financial soundness" (§ 2(a), 29 U.S.C. 1001(a)).

3. Although the result reached by the court below seems to conflict with the intent of Congress and to create dysfunctions in the operation of the statute, there is much in this Court's decision in *Metropolitan Life* directing the analysis of ERISA's preemption provisions toward that result.

a. Section 514(a) preempts "all State laws * * * [that] relate to any employee benefit plan."[7] Section 514(a) was added to ERISA by the Conference Committee; it replaced a narrower provision that preempted only state laws dealing with matters covered by ERISA, such as reporting and disclosure requirements and fiduciary responsibility. *Shaw*, 463 U.S. at 98. The bill's sponsors described Section 514(a) as providing for broad preemption of state law.[8] But Section 514(a) is "substantially qualified by an 'insurance saving clause,' § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), which broadly states that, with one exception, nothing in ERISA 'shall be construed to exempt or relieve any person from any law of any State which regulates insurance'" (*Metropolitan Life*, slip op. 7 (citation omitted)). Congress never explained the purpose of the saving clause (*id.* at 20 n.23), which was "in place well before the general pre-emption clause was amended to pre-empt broadly all laws that relate to plans" (*id.* at 16 n.17). Nor did the Conference Committee explain how the broadened preemption clause meshed with the saving clause. Finally, the "deemer clause" provides that no employee benefit plan "shall be deemed to be an insurance company or other insurer

[7] A state law "'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.'" *Metropolitan Life*, slip op. 13, quoting *Shaw*, 463 U.S. at 96-97.

[8] Representative Dent stated that "the reservation of Federal authority * * * to regulate the field of employee benefit plans" was the "crowning achievement" of ERISA. 120 Cong. Rec. 29197 (1974). Senator Williams stated that "with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Id.* at 29933.

* * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts" (§ 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B)).[9] This Court has described Section 514 as "perhaps * * * not a model of legislative drafting" (*Metropolitan Life*, slip op. 14), noting that "while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation" (*ibid.*).

b. Although the court of appeals was "not unmindful of the practical consequences of [its] decision" (Pet. App. 11a), it felt compelled to reach the result it did because of this Court's decision in *Metropolitan Life*. Indeed, as the court of appeals concluded, the Court in *Metropolitan Life* rejected a number of arguments that would have avoided the creation of a sharp distinction between insured and uninsured plans. This Court squarely rejected the argument that ERISA's saving clause was intended merely to preserve from preemption traditional state insurance laws such as those regulating the manner in which insurance may be sold (slip op. 15-16). And the Court noted that its construction of Section 514 resulted "in a distinction between insured and uninsured plans" (*id.* at 21) and that indirect state regulation of benefit plans through the regulation of insurance would result in disuniformities in national plans (*ibid.*). The Court nevertheless concluded that such results flowed from Congress's unexplained decision to save laws which regulate insurance from preemption and that "[a]rguments as to the wisdom of these policy choices must be directed at Congress" (*ibid.*).

[9] Two other provisions of ERISA concern the statute's relationship to state law. Section 4(b)(3), 29 U.S.C. 1003(b)(3), exempts from ERISA coverage employee benefit plans that are "maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws." And Section 514(b)(4), 29 U.S.C. 1144(b)(4), provides that ERISA does not preempt "any generally applicable criminal law of a State."

Metropolitan Life also rejected what may be the most natural reading of the relationship between the preemption, saving, and deemer clauses. As noted above, the preemption clause states that all state laws "relat[ing] to any employee benefit plan" are preempted. The saving clause then preserves state regulation of insurance. But the deemer clause may be read to limit the permissible extent of state insurance regulation by preventing state law from regulating employee benefit plans whether directly or indirectly. Under this reading the saving clause is narrowed considerably, but it continues to assure that the preemption clause is not given such broad scope as to interfere with state laws regulating insurance companies as business entities, for example. Reading the "deemer clause" to prevent state law from applying to employee benefit plans seems to comport with the legislative history. A 1977 House report stated (H.R. Conf. Rep. 94-1785, 94th Cong., 2d Sess. 46 (1977)): "There was a recognition of the necessity for the preservation of some state activity in this field and certain limited exceptions were made to the broad preemption scheme. In general these exemptions are designd to save state law as it is applied to entities which are not employee benefit plans as defined in [29 U.S.C. 1003(b)] to the extent that such regulation does not relate to employee benefit plans."[10] Nevertheless, the reasoning and result of *Metropolitan Life* preclude this reading of Section 514 since this construction would have led to preemption of the state law benefit requirement at issue in *Metropolitan Life*.

Finally, the Court in dictum also rejected the argument that the saving clause authorizes states to regulate only matters not specifically addressed in ERISA. The issue in *Metropolitan Life* was whether states may regulate the substantive content of insurance policies, an area not regulated by ERISA. The Supreme Judicial

[10] Although the language of the preemption clause was changed by the Conference Committee, the change broadened the preemption provision of ERISA from that included in the House bill. See page 9, *supra*.

Court of Massachusetts had held that since nothing in ERISA regulates the substantive content of benefit plans, indirect state regulation of such matters through the regulation of insurance was permissible (slip op. 10). The Court rejected the state court's approach to ERISA's saving clause, stating that "[n]othing in the language, structure, or legislative history of the Act supports * * * the Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA" (*id.* at 21). Rather, the Court concluded that "[i]f a state law 'regulates insurance,' * * * it is not preempted" by ERISA, even if ERISA covers the same subject matter as the state law (*ibid.*). The Court stated that the language of the saving clause requires this result because it provides that the other provisions of ERISA shall not be construed "to exempt or relieve any person from any law of any State which regulates insurance" (29 U.S.C. 1144(b)(2)(A)).

4. This case, like *Metropolitan Life*, requires analysis of the relationship between the preemption clause and the saving clause. Because of the deficiencies in the draftsmanship of these provisions and the absence of substantial illumination from the legislative history, we readily acknowledge that this task is necessarily uncertain. Yet we suggest that it is possible to give these two provisions—the preemption and the saving clauses—a construction which comports both with their commonsense meaning and with practicality. In *Metropolitan Life* the court accomplished this result at the expense of a certain measure of untidiness in the resulting scheme. Despite the generalized intent of Congress broadly to preempt state law, the words of the saving clause hardly left room for avoiding the conclusion that a state law imposing a mandatory term on insurance policies was "a law regulating insurance." But we see no reason to pursue that conclusion to the limit of its logic here by construing the saving clause to preserve rules of general applicability—such as those applying to all contracts or fiduciary relationships—even though such rules can certainly be made to relate to contracts and fiduciary

relationships concerning insurance. Moreover, while the Court in *Metropolitan Life* rejected the general notion that ERISA preempts state law that overlaps the federal statute's regulatory scheme, the Court's reasoning does not preclude a more specific argument that Congress particularly intended ERISA's provisions relating to enforcement of participants' rights under benefit plans to be exclusive.

a. This Court's decision in *Metropolitan Life* does not compel the result reached by the court of appeals here because common law causes of action of general applicability, unlike the mandated-benefit statute at issue in *Metropolitan Life*, are not laws which "regulate insurance." We think Congress most likely intended by the language of the saving clause to preserve exercises of state power specifically directed at the insurance industry.[11] The com-

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[11] However, we do not think it is satisfactory to distinguish this case from *Metropolitan Life* merely because this case involves decisional law while *Metropolitan Life* involved statutory law. For purposes of Section 514, "[t]he term 'State law' includes all laws, *decisions*, rules, regulations, or other State action having the effect of law, of any State" (29 U.S.C. 1144(c)(1) and (2) (emphasis added)). Therefore state common law, as formed by the decisions of state courts, fits the literal definition of "state laws" that may be preempted by Section 514(a) or saved from preemption by Section 514(b)(2)(A) as "law[s] * * * which regulate[] insurance." Indeed, every appellate court that has addressed the issue has found that ERISA's general preemption provision, Section 514(a), reaches state common law. See, *e.g.*, *Holland* v. *Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), appeal pending, No. 85-944, petition for cert. pending, No. 85-929 (state wage collection statute and state common law actions for breach of contract and estoppel); *Gilbert* v. *Burlington Industries, Inc.*, 765 F.2d 320, 326-328 (2d Cir. 1985), appeals pending, Nos. 85-441 and 85-460 (various state statutory and common law actions arising out of employers' severance pay policy); *Authier* v. *Ginsberg*, 757 F.2d 796, 800 (6th Cir. 1985), cert. denied, No. 85-230 (Oct. 7, 1985) (state cause of action for discharge in violation of public policy); *Blau* v. *Del Monte Corp.*, 748 F.2d 1348, 1356 (9th Cir. 1984), cert. denied, No. 84-2009 (Oct. 7, 1985) (state causes of action for breach of contract, fraud, and deceit); *Lafferty* v. *Solar Turbines Int'l*, 666 F.2d 408 (9th Cir. 1982) (state breach of contract action relating to administration of plan); *Dependahl* v. *Falstaff Brewing Corp.*, 653 F.2d 1208,

mon law causes of action respondent asserts are not specifically directed at the insurance industry. Rather, they are laws of general applicability that may be invoked by plaintiffs in a number of different settings. State laws should be saved from preemption by ERISA's saving clause only when they are specifically directed at insurance companies.

This approach seems to us to give "regulate" a common-sense meaning that is most likely to reflect Congress's intent, as the petitioners in *Taylor* contend (see Pet. Br. at 32-35). This Court has consistently given the terms of Section 514 their common-sense meaning (see *Metropolitan Life*, slip op. 13; *Shaw* 463 U.S. at 97). And, as a district court recently concluded, a "common sense analysis of the word 'regulate' precludes" application of the saving clause to avoid preemption of general common law causes of action (*Benvenuto*, slip op. 16). This common-sense interpretation is strengthened by comparison of the word "regulate" in the saving clause with Congress's use of the phrase "relates to" in the preemption clause. If Congress had intended to preserve state laws affecting insurance matters as broadly as it intended to preempt state laws affecting benefit plans, it could have used the phrase "relates to" in the saving clause. The fact that it used "regulate" instead supports the conclusion that it does not save from preemption general state laws that affect insurance companies but only

1214-1216 (8th Cir.), cert. denied, 454 U.S. 968 (1981) (state claim of tortious interference with plan). Petitioners urges (Reply Br. 3-4 n.1) that although Congress defined "State law" for all of Section 514, it intended the definition to apply only to Section 514(a), where the phrase "any and all State laws" is used, and not to Section 514(b) where, in both the saving clause and the deemer clause, the phrase "any law of any State" is used. This argument is unpersuasive. It requires a distinction between "any and all State laws" and "any law of any State," two phrases that appear to mean exactly the same thing. *Lessard* v. *Metropolitan Life Ins. Co.*, 618 F. Supp. 1268, 1270-1271 (D. Me. 1985).

state laws that are focused on the insurance industry.[12] In addition, in the deemer clause Congress referred to state laws "purporting to" regulate insurance. That phraseology indicates Congress was thinking of laws specifically directed at the insurance industry, since only such laws "purport" to regulate insurance companies and insurance contracts. Common law causes of action, in contrast, do not purport to regulate insurance.

We recognize that an interpretation of the saving clause that preserves only state laws specifically directed at insurance may result in some difficult line-drawing problems. For example, some states recognize, in their common law, a separate and specific tort remedy for bad faith refusal to honor a claim for benefits. See *Anderson* v. *Continental Ins. Co.*, 85 Wis. 2d 675, 271 N.W.2d 368, 374 (1978). To the extent that such a remedy is specifically directed at the insurance industry it may be argued that it should be preserved by the saving clause even though general contract law claims are not. On the other hand it may be that because a tort action for bad faith refusal to honor a claim for benefits is simply an application of general common law principles, the saving clause should not preserve such a state cause of action. In addition, a state legislature may attempt to avoid federal preemption by enacting a statute making specific provision for benefit claims against insurance companies. We do not think it wise to adopt

[12] We acknowledge that in some sense general common law causes of action can be said to "regulate" insurance. The regulatory nature of court decisions on insurance transactions is recognized by a leading text: "Courts, too, have had a significant role in the regulation of insurance transactions and institutions. A very limited part of this role is concerned directly with judicial proceedings for enforcement of regulatory measures initiated by a commissioner of insurance within authorizations granted by statute. More significant is the continuing role of the courts in the regulation of insurance transactions through doctrinal developments." R. Keeton, *Basic Text on Insurance Law* § 8.1(b), at 543 (1971). We do not think, however, that Congress meant to save laws that "regulate" in such a manner. It seems far more likely Congress was thinking of state laws focused on the insurance industry.

the troublesome result reached by the court of appeals here merely in order to avoid these difficulties.[13]

This Court stated in *Metropolitan Life*, slip op. 18-19 n.21, that the meaning of the phrase "business of insurance" in the McCarran-Ferguson Act, 15 U.S.C. (& Supp. II) 1011 *et seq.*, is "directly relevant" to determining the meaning of ERISA's saving clause which, "with its similarly worded protection * * * appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." The court of appeals in this case relied upon the McCarran-Ferguson Act to support its conclusion; however the result it reached is not the inevitable or even the best application of McCarran-Ferguson principles.

This Court examines three criteria in determining whether a practice is part of the business of insurance within the meaning of the McCarran-Ferguson Act: " '*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " See *Metropolitan Life*, slip op. 17 (emphasis in original), quoting *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982). See also *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979). As the court of appeals concluded (Pet. App. 10a-11a), the state law claims respondent asserts implicate the second criterion, the policy relationship between the insurer and the insured. This Court has stated that

[13] The problem of anomalous results caused by a holding that only laws specifically focused on the insurance industry regulate insurance within the meaning of the saving clause would not be presented if the Court holds that Congress intended the procedures it established in Section 502 to be the exclusive procedures for enforcing claims for benefits, as we suggest below (pages 18-19, *infra*).

the "core of the 'business of insurance' [is] * * * [t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement" (*Metropolitan Life*, slip op. 18, quoting *SEC* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969)); see also, *Pireno*, 458 U.S. at 132. The essence of respondent's claim is that petitioner violated the terms of its contract with him by refusing to pay his claim for long-term disability benefits and whether a claim is paid is central to the relationship between an insurer and an insured.

However, the laws respondent invokes do not appear to involve the first or third McCarran-Ferguson criteria. They do not effect a transferring or spreading of risk, and this Court has stated that "one 'indispensable characteristic of insurance' is the 'spreading and underwriting of a policyholder's risk' " (*Pireno*, 458 U.S. at 127 (quoting *Royal Drug*, 440 U.S. at 211-212)). Thus while the "core" of the business of insurance may be implicated here, an "indispensable characteristic" of that business is not. And as common laws of general applicability, the laws respondent invokes are not specifically limited in their effect to entities in the insurance industry, so the third McCarran-Ferguson criterion is not satisfied here. Thus we do not think that the McCarran-Ferguson Act supports the result reached by the court of appeals here.[14]

Moreover, special care should be taken in applying these criteria to the problem of preempting state common law. The McCarran-Ferguson Act itself does not preserve state decisional law; the statute refers only to laws "enacted by" a state. 15 U.S.C. 1012(b). Therefore the

[14] The Second and Tenth Circuits have concluded that state arbitration statutes, which are laws of general applicability that provide a forum for the resolution of disputes regarding insurance contracts, are not state regulation of insurance under the McCarran-Ferguson Act. *Hamilton Life Ins. Co.* v. *Republic Nat'l Ins. Co.*, 408 F.2d 606 (2d Cir. 1969); *Hart* v. *Orion Ins. Co.*, 453 F.2d 1358 (10th Cir. 1971).

criteria developed to determine whether the McCarran-Ferguson Act preserves state law were not specifically designed to deal with the problems that attend a determination whether state decisional law is law "which regulates insurance."

b. In our view the court below also too quickly dismissed the argument that the state remedies at issue here should be held to be preempted because ERISA's own remedial scheme for recovery of benefits was intended to be exclusive. We believe there is substantial support in the language and legislative history of ERISA for preserving the exclusivity of ERISA's remedial provisions, even if state law may coexist with federal law in other areas covered by ERISA.

As discussed above (pages 11-12, *supra*), *Metropolitan Life* rejected the Massachusetts Supreme Judicial Court's theory that ERISA saved only state regulations unrelated to the substantive provisions of ERISA. The Court's rejection of this approach appears to preclude an argument that respondent's state law claims are preempted solely because ERISA provides procedures for plan participants to enforce their rights. However, while Congress may not have intended its treatment of other matters governed by ERISA to preclude state regulation of those matters, we think that Congress intended ERISA's provisions relating to enforcement of participants' rights under benefit plans to be exclusive. As petitioner states (Pet. 10-13), Congress established a detailed enforcement scheme in Section 502 so that plan participants may enforce their rights under benefit plans governed by ERISA.

Moreover Congress made clear that federal common law rather than state law was to be applied in determining claims brought under Section 502 to recover ERISA benefits. The Conference Committee report stated (H.R. Conf. Rep. 93-1280, 93d Cong., 2d Sess. 327 (1974)): "Under the conference agreement, civil actions may be brought by a participant or beneficiary to recover

benefits due under the plan, to clarify rights to receive future benefits under the plan, and for relief from breach of fiduciary responsibility. * * * *All such actions in Federal or State courts are to be regarded as arising under the laws of the United States* in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." 29 U.S.C. 185. This language clearly suggests that Congress intended the remedies it provided in Section 502 to be exclusive. It would be quite peculiar for Congress to have failed to mention in those sections of the committee reports dealing with Section 502 that alternative enforcement procedures in the form of state common law causes of action existed for those many employees participating in insured plans if in fact Congress did not intend the remedies provided in Section 502 to be exclusive.[15] Therefore even though in general the fact that Congress addressed a matter in ERISA does not by itself preclude states from addressing the matter in insurance laws, we think that since Congress intended the procedures it established in Section 502 to be the exclusive procedures for enforcing claims for benefits due under employee benefit plans, the states are barred from establishing alternative procedures.

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[15] A study commissioned by the Department of Labor showed that 91% of the health plans covering fewer than 100 employees were insured and administered by the insurance company and that 83% of the health plans covering 100 or more employees were insured and administered by the insurance company. 4 Health and Population Study Center, Battelle Human Affairs Research Centers, *Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-1979*, at 44 (1980) (available from the National Technical Information Service, Springfield, Va., No. PB81-180366). Thus under the court of appeals' decision the vast majority of employees participating in plans like the one in which respondent participated would be able to pursue remedies other than those provided in Section 502.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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MAY 1986

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SUPPLEMENTAL BRIEF

(7)

No. 85-1043

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

PILOT LIFE INSURANCE CO.,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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SUPPLEMENTAL BRIEF FOR RESPONDENT

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SUPPLEMENTAL BRIEF FOR RESPONDENT

At the Court's invitation, the Solicitor General has filed an *amicus* brief expressing the views of the United States. Significantly, the Solicitor General makes clear that the arguments of Petitioner and *amici* are invalid.

Indeed, the government agrees with the Respondent on every important point: the Petitioner is an insurance company; the insurer-insured relationship exists between Petitioner and Respondent; there is at present no conflict between this case and the decision of any other court of appeals [1]; every appellate court has found that ERISA's general preemption provision reaches state common law [2];

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[1] The Government disagrees with the entirety of the Petitioner's Supplemental Brief, *see* Brief for the United States at 5 n.4, and exposes the disingenuous argument that *Powell v. Chesapeake and Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), creates a conflict between circuits. Unlike the Petitioner, the Government understands the difference between insured and self-insured plans.

[2] Petitioner's effort to distinguish this case (involving decisional law) from *Metropolitan Life* (involving statutory law) is "[un]-

§ 514(a) is "substantially qualified" by the insurance saving clause; the case *sub judice* is controlled by *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985); and the Fifth Circuit Court of Appeals correctly relied on that decision.

The Government agrees only with the ultimate position taken by Petitioner and *amici*—i.e., that this Court should reconsider the *Metropolitan Life* decision. That position is without merit in light of the thorough and complete analysis given the issues in *Metropolitan Life* and this Court's recognition that deference should be afforded Congress to address them.[3] Like the Petitioner and *amici*, the Solicitor General does not want to accept the *Metropolitan Life* decision.

CONCLUSION

For these reasons and those set forth in the Respondent's original brief in opposition, it is respectfully submitted that the petition for writ of certiorari should be denied.

Respectfully submitted,

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satisfactory" and its argument that the term "State law" should apply only to § 514(a) and not § 514(b) is "unpersuasive." *See* Brief for United States at 13-14 n.11.

[3] Of course, the result sponsored by all in favor of the petition is nothing more than a "speculative attempt to read the saving clause out of the statute," *Metropolitan Life*, 105 S.Ct. at 2393, a notion soundly rejected by this Court.

JOINT APPENDIX

(9)

No. 85-1043

IN THE

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JOINT APPENDIX

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September 5, 1986

PETITION FOR CERTIORARI FILED DECEMBER 16, 1985
CERTIORARI GRANTED JUNE 30, 1986

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI

No. S80-0467

EVERATE W. DEDEAUX,
Plaintiff,
v.

PILOT LIFE INSURANCE COMPANY and ENTEX, INC.,
Defendant.

DOCKET ENTRIES

DATE	PROCEEDINGS
5-30-80	Complaint, original and 3 copies, filed.
5-30-80	Notice of Interrogatories and Interrogatories propounded to Pilot Life Ins. Co., original and 2 copies, filed.
5-30-80	Notice of Interrogatories and Interrogatories propounded to Entex, Inc., original and 1 copy, filed.
5-30-80	Request for Discovery and Production of Documents propounded to Pilot Life Ins. Co. original and 2 copies, filed.
5-30-80	Request for Discovery and Production of Documents propounded to Entex, Inc., original and 1 copy, filed.
5-30-80	Summons issued, original and 3 copies, copies having attached copy of complaint and above proceedings and mailed to U.S. Marshal for service with a copy of consent mailed to attys.
6-5-80	Marshal's return on summons, executed as to Entex, Inc. on 6-3-80, filed.
6-12-80	Marshal's return on summons, executed as to Pilot Life Ins. Co. by service on Commission of Ins. on 6-9-80, filed.

DATE	PROCEEDINGS
6-25-80	Motion of defendant, Entex, Inc. for Enlargement of Time with certificate of Service, filed.
6-25-80	Notice that above motion is being uncontested and agreed to by attorneys and will not be called for hearing, filed.
6-27-80	Answer of Pilot Insurance Company with exhibits attached and certificate of service, filed.
7-11-80	First set of Interrogatories of Entex, Inc. to Plaintiff, with certificate of service, filed.
7-14-80	AGREED ORDER—Entex, Inc. granted 30 additional days down to and including 7-23-80 to answer complaint, Request for Discovery and Production of Documents and Interrogatories, filed and entered in OB-1980, page 2469. Copies to attorneys.
7-15-80	ANSWER of Entex, Inc., with certificate of service, filed.
7-17-80	Answer of Pilot Life Ins. Co. to Interrogatories, with Affidavit of David A. Mitchell, with certificate of service, with attachments, filed.
10-17-80	First set of interrogatories propounded by defendant, Pilot Life Insurance Company, to plaintiff with certificate of service, filed.
12-10-80	Motion of Plaintiff and defts for additional time for discovery, AGREED) filed. (Agreed Order to Judge Roper for signatures)
12-10-80	ORDER—discovery is extended for a period of 90 days from 12-10-80, filed and entered in OB-1980, page 3733. Copies to attorneys.
2-27-81	Notice that deposition will be taken of Plaintiff on 3-5-81 at 1:30 PM in Biloxi, Ms., with certificate of service, filed.
3-6-81	Response of defendant, Entex, In. to plaintiff's request for production for discovery and production of documents and things with certificate of service, filed.

DATE	PROCEEDINGS
3-6-81	Response of defendant, Entex, Inc. to interrogatories propounded by the plaintiff with certificate of service, filed.
3-17-81	Plaintiff's answers to Interrogatories propounded by Pilot Life Ins. Co., with Affidavit of Everate W. Dedeaux, with certificate of service, filed.
3-17-81	Plaintiff's Answers to Interrogatories propounded by Entex, Inc., with Affidavit of Everate W. Dedeaux, with certificate of service, filed.
4-8-81	Deposition of Everate W. Dedeaux taken on March 20, 1981 at Biloxi, Ms., filed.
4-8-81	Deposition of Everate W. Dedeaux taken on March 19, 1981 at Biloxi, Ms., filed.
4-13-81	ORDER: That the time for discovery in this action be and the same is hereby extended for a period of ninety (90) days from and after this date, filed and entered in OB 1981-page-1173.
8-17-81	Motion (AGREED) of Plaintiff of additional time for discovery, with certificate of service, filed.
8-19-81	ORDER—Plaintiff and defts allowed 60 days additional time to complete discovery, filed and entered in OB-1981, page 2185. Copies to attorneys.
4-13-82	Motion of Entex, Inc. for Summary Judgment, with certificate of service, filed.
4-13-82	NOTICE that above motion be heard before Judge Russell on 5-17-82 at 9 AM in Gulfport, with certificate of service, filed.
4-13-82	Addendum to Motion for Summary Judgment, with attached Exhibit A (Affidavit of R. L. Massingill), with certificate of service, filed.
4-16-82	Request for Admission of Documents to Pilot Life Ins. Co., with attachments, with certificate of service, filed.

DATE	PROCEEDINGS
5-12-82	Motion of Pilot Life Ins. Co. for leave to amend answer, with attached NOTICE that motion be heard before Judge Roper on 5-27-82 at Biloxi, Ms., with certificate of service, filed (Attached Exhibit A)
5-13-82	Response to request for admission of documents to Pilot Life Ins. Co., with certificate of service, filed.
5-24-82	FINAL JUDGMENT—filed judgment entered for deft, Entex, Inc. and against Pltf. with all costs herein assessed to plaintiff, filed and entered in OB-1982, page 1884. Copies to attorneys.
5-24-82	MEMORANDUM OPINION, filed. (copies mailed by Judge Russell's Office)
5-24-82	DEPUTY CLERK SHEET—Motion of Entex, Inc. for Summary Judgment heard before Judge Russell on 5-17-82 in Gulfport, Ms., Action Taken: Sustained; proposed findings of fact and conclusions of law together with separate order to be submitted, filed.
6-28-82	AMENDED NOTICE that Motion of deft. for leave to amend answer will now be heard before Judge Roper on 7-7-82 at 9 AM in Biloxi, Ms., with certificate of service, filed.
7-8-82	Bill of Costs filed by Entex, Inc. in the amt. of $297.38, filed.
7-12-82	Bill of Costs filed by Entex, Inc. in amt. of $297.38, taxed.
7-12-82	Second AMENDED NOTICE that Motion for Leave to Amend Answer be heard before Judge Roper on 7-29-82 at 9 AM in Biloxi, Ms., with certificate of service, filed.

DATE	PROCEEDINGS
	DEPUTY CLERK SHEET:
7-30-82	Motion to Amend heard before Judge Roper on 7-29-82 in Biloxi, Ms. Action Taken: Motion to Amend Answer granted, filed.
8-4-82	ORDER—Motion for Leave to Amend Answer by Deft Pilot Life Ins. Co. be granted anl they are permitted to file Amended Answer in form set forth as Exhibit A to Motion, filed and entered in OB-1982, page 2702. Copies to attorneys.
8-6-82	AMENDED ANSWER and counterclaim of Pilot Life Ins. Co. to complaint, with certificate of service, with attachment, filed.
9-3-82	ANSWER of Pltf to Counterclaim, with Cert. of Service, filed.
9-3-82	Notice of and attached Pltf's Second Set of Interrogatories Propounded to Deft, with Cert. of Service, filed.
9-3-82	Pltf's Request for Discovery and Production of Documents and Things for Inspecting Copying or Photographing Pursuant to Rule 34, with Cert. of Service, filed.
9-17-82	Deft. Pilot Life's Motion to Strike, etc., w/NOTICE of hearing 9-30-82, cert. of serv., filed.
9-29-82	Amended Notice of Motion to stirke or dismiss answer to counterclaim will be now heard on 11-18-82 in Biloxi, Ms., with certificate of service, filed.
10-6-82	Answer of Pilot Life Ins. Co. to second set of interrogatories, with certificate of service, filed.
10-6-82	Response of Pilot Life Ins. Co. to request for discovery and production of documents and things, with certificate of service, filed.
10-21-82	Notice that deposition will be taken of Rod Clark on 10-27-82 at 1:30 PM in Jackson, Ms., with certificate of service, filed.

DATE	PROCEEDINGS
11-1-82	Marshal's return on subpoena duces tecum, executed at to Rod Clark on 10-26-82, filed.
11-16-82	CONSENT TO PROCEED BEFORE A UNITED STATES MAGISTRATE—ORDER—matter is referred to U.S. Magistrate for *hearing on Defendant's Motion to Strike Answer to counterclaim,* filed and entered in OB-1982, page 4149. Copies to attorneys. DMR
11-24-82	Second Set of Interrogatories Propounded by Deft., Pilot Life Insurance Company, to Pltf., with Cert. of Service, filed.
11-24-82	Deft's. Request for Admissions to Pltf., with Cert. of Service, filed.
12-13-82	AMENDED NOTICE that Motion to strike or dismiss answer to counterclaim will be heard before Judge Roper on 12-15-82 at 3:30 PM in Biloxi, Ms., with certificate of service, filed.
12-15-82	DEPUTY CLERK SHEET—before Judge Roper on 12-15-82 in Biloxi—Action Taken: Motion to strike or dismiss answer to counterclaim by deft. is denied. Plaintiff's motion ore tenus for extension of time to file answer to counterclaim, granted, filed.
1-11-83	Deposition of Mr. Rodney Martin Clark taken on October 27, 1982, (3 volumes).
1-12-83	ORDER: That Motion of Defendant to strike or dismiss Plaintiff's Answer to Counterclaim, is hereby overruled. Plaintiff's motion for additional time has been granted, filed and entered in OB-1983, pages 224-225 (JMR) Copies mailed to attorneys.
4-19-83	Motion of Pilot Life Insurance Company, Defendant, For Summary Judgment, or, Alternatively, For Partial Summary Judgment, with Certificate of Service, filed. (Copy to Gwen along with Copy of Docket Entries)

DATE	PROCEEDINGS
4-19-83	NOTICE that the above Motion will be heard before Judge Russell on May 2, 1983, at 9:00 A.M., in Gulfport, Mississippi, with Certificate of Service, filed. (Copy to Gwen)
	SET FOR PRE-TRIAL, AUGUST 8, 1983
8-11-83	Plaintiff's Answer To Second Set of Interrogatories Propounded by Defendant, Pilot Life Insurance Company, with Cert. of Service, filed.
8-11-83	Plaintiff's Responses To Request For Admissions, with Cert. of Service, filed.
10-03-83	MEMORANDUM OPINION. filed. (DMR)
10-13-83	Deft's Amended Answer to Second Set of Interrogatories, with Cert. of Service, filed.
10-13-83	Motion of Deft to Quash, with Cert. of Service, with NOTICE that motion will be heard on 1-5-84 at 9:00 AM before Judge Roper in Biloxi, MS, with Cert. of Service, filed.
11-15-83	Motion of Deft to Reconsider, with Cert. of Service, with NOTICE that motion will be heard on 12-5-83 at 9:00 AM before Judge Russell in Gulfport, MS, with Cert. of Service filed.
1-13-84	DEPUTY CLERK SHEET: Hearing on Motion to Compel held before Judge Roper on 1-5-84 in Biloxi; ACTION TAKEN: Court wants Pltf to make independent investigation with regard to Deft's witnesses who say they witnessed the events set forth in the Request for Admissions. After this, he will be allowed to file motion to withdraw Answers to Request for Admission. Court assessed Pltf atty's fees of $300.00 for deft having to come here for motion. Court stated if remedies of 37(c) are set forth at trial the Court will impose penalties that rule requires, filed.

DATE	PROCEEDINGS
2-10-84	DEPUTY CLERK SHEET: Hearing on Deft's motion to reconsider held before Judge Russell on 2-9-84 in Gulfport, MS; ACTION TAKEN: Reserved ruling, filed.
2-22-84	ORDER: that pltf's response to request for admissions was filed more than 30 days after service as governed by Rule 36 of FRCP; pltf's motion to withdraw admissions caused by late responses as relats to Deft's Request No. 1, including its subparts, is conditionally granted as stated in order; pltf's motion ti withdraw admissions caused by late responses as relates to Defts no. 2 & 3 is unconditionally granted, and pltf is allowed to deny same; atty's fees are assessed against pltf in amt of $300.00, filed and entered in OB-1984, Pages 801-802. JMR. Copies mailed to attys.
02-21-84	Notice that Deft will take deposition of William C. Hooper, Jr. on 2-22-84 at 1:30 PM in Gulfport, MS, with Cert. of Service, filed.
3-7-84	ORDER GRANTING LEAVE TO TAKE DEPOSITION OF A PERSON CONFINED IN PRISON: that on Motion of Deft. Pilot Life Insurance Company to take deposition of Mary Ann Gerlach, a person confined in Mississippi State Penitentiary at Parchman, Mississippi, Court having considered this motion finds it is well taken and orders deposition may be taken according to such terms and conditions as Mississippi State Penitentiary at Parchman, Mississippi, may require, filed and entered OB-1984, page 1036. Copies to attys. (JMR)
3-7-84	Notice that deft., Pilot Life Insurance Company, will take deposition of Mary Ann Gerlach at Mississippi State Penitentiary, Parchman, Mississippi, Monday, 3-12-84, 10:00 a.m., with Cert. of Service, filed.
3-09-84	Plaintiff's Response to Request For Admissions, with Cert. of Service, filed.

DATE	PROCEEDINGS
3-12-84	Notice that Deposition will be taken of Dr. Robert L. White in Mobile, Alabama, on March 14, 1984, at 10:30 A.M., with Cert. of Service, filed. (attachment filed in error; removed & mailed back to Atty Harry E. Neblett, at his req. 3-13-84)
3-12-84	DEPUTY CLERK SHEET: Pretrial held before Magistrate John M. Roper in Biloxi, Ms., on March 7, 1984. ACTION TAKEN: P.T.O. to be submitted by Monday. J.I. submitted, filed.
3-13-84	Pltf's Motion for Protective Order, with Cert. of Service, filed. (Copy to Gwen)
3-14-84	Deft's Notice to Take Deposition of Dr. Buford Yerger 3-20-84 in Jackson, HS, with cert. of service, filed.
3-14-84	ORDER: Ordered that the deft. is prohibited from taking the deposition of Robert L. White noticed for March 14, 1984, filed and entered in OB-1984, p. 1142. BRS.
3-15-84	Deft's Notice to Take Deposition of Dr. James T. Williams 3-22-84 in New Orleans, LA, with Cert. of Service, filed.
3-19-84	Motion of Pltf for Protective Order, with Cert. of Service, with attached Exhibit "A", filed. (to be heard this date per Ronald Cochran) (before JMR)
3-19-84	Motion of Pltf for Protective Order, with Cert. of Service, with attached Exhibit "A", filed. (to be heard this date per Ronald Cochran) (before JMR)
3-19-84	Motion of Pltf to Suppress Use of Deposition at Trial, with Cert. of Service, with attached Exhibit "A", filed. (no notice)
3-21-84	OPINION of the Court, filed. DMR. (Pat mailed copies to attorneys)
3-21-84	Copy of cover sheet of deposition of Dr. William C. Hopper, Jr., filed.

DATE	PROCEEDINGS
3-21-84	Copy of cover sheet of deposition of Mary Ann Gerlach, filed.
3-22-84	FINAL JUDGMENT: that final judgment be entered in cause for deft, Pilot Life Insurance Company, and against the Pltf, Everate W. Dedeaux, with all costs herein assessed to pltf, filed and entered in OB-1984, Page 1311. DMR. Dkt'd 3-22-84. Copies mailed to attys.
	JS 6 CARD
3-23-84	Exhibits in Support of Deft's Motion for Summary Judgment, or, in the Alternative, for Partial Summary Judgment, (exhibits A-J), filed.
3-29-84	ORDER: that deft is permitted to proceed with taking of deposition of Dr. Buford Yerger noticed for March 20, 1984, filed and entered in OB 1984, Page 1463. BRS. Copies mailed to attys.
3-29-84	Copy of cover sheet of Deposition of Dr. Buford Yerger taken 3-20-84 at 1:10 p.m. in Jackson, filed.
3-29-84	NOTICE OF APPEAL: Given that pltf appeals to the Fifth Circuit from the Final Judgment rendered in this cause on March 22, 1984, pursuant to an Order Granting Defendant's Motion for Summary Judgment, with cert. of service, filed.
3-29-84	Appeal Information Sheet and Appellant's Purchase Order for Transcript mailed to Atty William L. Denton.
3-29-84	Copy of Notice of Appeal mailed to Bobbie Price.
3-29-84	Letter to 5 CA with certified copy of Notice of Appeal and Docket Entries.
4-4-84	Copy of cover sheet of deposition of Mary Ann Gerlach taken 3-12-84, filed.
4-4-84	Letter from Atty Harry E. Neblett, Jr., dated 4-3-84, giving explanation why they are requesting the cover sheet of deposition of Mary Ann Gerlach to be filed a second time, filed.

DATE	PROCEEDINGS
4-10-84	Appeal Information Sheet returned showing "Transcript is Unnecessary for Appeal Purposes", filed. (Copy mailed to B. Price)
4-11-84	Entire file mailed to Fifth Circuit.
5-24-84	Pltf's Motion to Supplement Appeal Record, with cert. of service, with Notice to be heard before Judge Russell 6-6-84 at 9:00 a.m., Gulfport, MS, filed.
6-7-84	DEPUTY CLERK SHEET: Hearing on Motion to Supplement Appeal Record held before Judge Russell on 6-6-84 in Gulfport; ACTION TAKEN: excerpts taken from one deposition to be included in record on appeal. Order to be submitted, filed.
6-19-84	ORDER ALLOWING APPEAL RECORD TO BE SUPPLEMENTED: Ordered and Adjudged that the appeal record in this cause be supplemented to include the deposition excerpts of John E. Mobley which were provided in support of Pltf's Memorandum Response in Opposition to Motion for Summary Judgment, specifically pages 21, 24, 27, 33, 66, 87, 95 and 96, filed and entered in OB-1984, pages 4362 thru 4371. DMR. Copies mailed attys.
6-19-84	Supplemental record, including Notice of Hearing and Motion to Supplement Appeal Record, Deputy Clerk Sheet, Order Allowing Appeal Record to be Supplemented, including deposition pages 21, 24, 27, 33, 66, 87, 95 and 96 of John E. Lundy, sent 5 CA by Registered Mail.
8-20-84	(Fifth Circuit) Defendant/Appellee Pilot Life Insurance Company's Motion to Dismiss Appeal for Lack of Jurisdiction, with cert. of service, filed.
8-20-84	(Fifth Circuit) Appellant's Response to Appellee's Motion to Dismiss Appeal for Lack of Jurisdiction, with cert. of service, filed.

DATE	PROCEEDINGS
8-20-84	(Fifth Circuit) Defendant/Appellee Pilot Life Insurance Company's Motion to Strike Portions of Appellant's Brief, with attached Brief in Support, with cert. of service, filed.
8-20-84	(Fifth Circuit) ORDER: that appellee's motion to strike portions of appellant's brief is moot. Ordered that appellee's motion to dismiss the appeal is considered and the court grants a limited remand to the district court for the opportunity for that court entering either a final judgment or a Rule 54(b) order. If that is not done and filed with the clerk of the court of appeals by 9-4-84 the appeal will be dismissed. Filed and entered in OB-1984, p. 5727. Copy mailed Judge Russell.
8-22-84	CERTIFICATION UNDER RULE 54(b), signed by Judge Dan M. Russell, filed.
8-22-84	FINAL JUDGMENT: that the final judgment be entered in this cause for the Defendant, Pilot Life Insurance Company, and against the Plaintiff, Everate W. Dedeaux, with all costs herein assessed to Plaintiff, filed and entered in OB 1984, pages 5848 thorugh 5850, copies mailed to attorneys, filed. (Pages include above Certification) (DMR) (Dk'td 8-22-84)
8-24-84	SUPPLEMENTAL RECORD ON APPEAL CONSISTING OF ALL OF THE ABOVE ENTRIES FORWARDED TO 5TH CIRCUIT.
10-22-85	MANDATE FROM FIFTH CIRCUIT: It is now here ordered and adjudged by this Court that the order of the District Court appealed from in this cause is reversed, and the cause is remanded to the District Court for further proceedings in accordance with the opinion of this Court; that defendant-appellee pay to plaintiff-appellant the costs on appeal, to be taxed by the Clerk of this Court; filed and entered in OB-1985, p. 6235. (cc mailed Judge Russell)

DATE	PROCEEDINGS
10-22-85	SLIP OPINION, filed. (cc mailed Judge Russell)
10-22-85	5 CA Bill of Costs, filed.
	JS 5A card
11-12-85	SET FOR PRETRIAL 2-3-86.
11-27-85	Motion of Deft to Stay Proceedings in District Court Pending Resolution of Application for Writ of Certiorari in United States Supreme Court and for Subsequent Further Discovery, with NOTICE that motion will be heard as soon as counsel can be heard, with Cert. of Service, filed.
12-19-85	ORDER GRANTING CONTINUANCE: case continued and removed for pre-trial conference calendar on 2-3-86 and from trial calendar 2-17-86 to 3-7-86; parties will appear before Court on 2-3-86 for status conference; at status conference, Court will determine period of discovery required by deft, filed and entered in OB-1985, Page 7457. BRS. Copies to attys.
1-6-86	DEPUTY CLERK SHEET: Hearing on Motion to Stay Proceeding pending resolution of app for W/C in US Supreme Court held before USM Singletary on 12-12-85 in Biloxi; ACTION TAKEN: Continued from trial docket in February, but will remain on PTC Calendar for status conference. Counsel is excused from PT materials. Will decide on ext. of time for discovery after writ of cert. has been decided, filed.
1-28-86	ORDER: that Harry E. Neblett, Jr. granted leave to withdraw as counsel of record for deft, filed and entered in OB-1986, Page 527. DMR. Copies to attys.
1-29-86	Motion of Harry E. Neblett, Jr. for Leave to Withdraw as Counsel, with Cert. of Service, filed (Order previously filed)

DATE	PROCEEDINGS
2-7-86	DEPUTY CLERK SHEET: Pretrial before USM Singletary in Biloxi, MS, 2-3-86. ACTION TAKEN: Conference call—case off calendar—writ of cert. filed. BRS will have formal status conf. once ruling handed down. Each counsel bringing lists of witnesses and discuss what is left to be done to conference. At that time will enter an order for specific discovery and set firm deadlines, filed.
7-18-86	IN COMPLIANCE WITH TELEPHONE REQUEST THIS DATE FROM GEORGE BAUER, USCA, ENTIRE RECORD ON APPEAL FORWARDED TO USCA (EXCLUDING EXHIBITS FILED 3-23-84).

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 84-4201

EVERATE W. DEDEAUX,
Plaintiff-Appellant,

v.

PILOT LIFE INSURANCE COMPANY,
Defendant-Appellee.

DOCKET ENTRIES

DATE	FILINGS—PROCEEDINGS
1984	
March 30	Date Docketed; Dup. Notice of Appeal & Clerk's Statement of Docket Entries Fld.
Apr. 12	Record on Appeal filed, 2 volumes; exhibits filed, 1 box. Briefing Notice Issued.
Apr. 13	Appearance of Counsel filed, Denton, Persons, Dornan & Bilbo, William L. Denton, Ronald S. Cochran for Appellant. -do -
Apr. 17	Appearance of Counsel filed, Heidelberg, Woodliff & Franks, Harry E. Neblett, Jr., George F. Woodliff III for Appellee. - do -
May 18	Fld. Motion for Extension of time for Appellant's Brief
May 29	Fld. Order gntg Appellant an ext of time to file Brief to: 5-29-84
May 31	Brief for Appellant filed.

DATE	FILINGS—PROCEEDINGS
1984	
June 20	Supplemental Record Fld., 1 volume.
July 2	Fld. Motion For Extension of time for Appellee's Brief
July 20	Fld. Order gntg Appellee an ext of time to file Brief to: 7-20-84
July 23	Brief for Appellee filed. Motions to Dismiss for lack of Jurisdiction and to Strike Portions of Appellant's Brief by Appellee filed.
July 30	Appellant's response to Appellee's Motion to Strike Portions of Brief fld. Appearance of counsel filed, Keith R. Raulston, Heidelberg, Woodliff & Franks for Appellee. - do -
Aug. 3	Fld. Motion & Order gntg Appellant an ext of time to file Reply Brief to: 8-13-84. Appellant Response to Appellee Motion to Dismiss fld.
Aug. 6	Flg. Appellee's rebuttal brief supporting motion to dismiss appeal for lack of jurisdiction. (sub TMR-8-7)
Aug. 14	Reply Brief for Appellant filed.
Aug. 17	Flg. order that Appellee's motion to strike portions of Appellant brief is moot; further that Appellee's motion to dismiss appeal is considered and the court grants a limited remand to the D.C. for the opportunity for that court entertaining either a final judgment or a Rule 54(b) order. If that is not done and filed with the Clerk of the Court of Appeals by 9/4/84, the appeal will be dismissed. (TMR, HAP, EGJ)
Aug. 27	Second Supp. Record fld; 1 volume.
Nov. 2	Case assigned for 12-4-84 in EB.

DATE	FILINGS—PROCEEDINGS
1984	
Dec. 4	Case Argued and submitted before JRB-JSW-WG. Appearance of counsel, William C. Walker, Univ. of Ms. Law Center for Appellant.
1985	
May 20	Rule 28(j) letter—Appellant fld. (J)
May 28	Rule 28(j) letter—Appellee fld. (J)
June 11	Rule 28(j) letter—Appellant fld. (J)
Aug. 9	Supp. Brief for Appellee fld. (J)
Aug. 12	Supp. Brief for Appellant fld. (J)
Sept. 16	Opinion rendered—reversed; JSW; signed
Sept. 26	Bill of Costs
Oct. 4	Motion for Stay of Mandate fld by Appellee
Oct. 10	Appellee's response to Motion for Stay of Mandate fld. submitted JEW
Oct. 17	Motion for Stay of Mandate denied by Court.
Oct. 18	Jdgt as Mdt Issd to Clerk; Record on Appeal Rtd to Clerk (2 vols. 2 suppl. vols.); Exhibits Retd to Clerk (1 box).
Dec. 23	Notice of Flg. of Cert. Pet. on 12-16-85 No. 85-1043
1986	
July 3	Order of S.C. granted 6-30-86
July 23	Preparing Proceedings on Certiorari

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
THE SOUTHERN DIVISION

Civil Action No. S80-0467

EVERATE W. DEDEAUX,
Plaintiff,
versus

PILOT LIFE INSURANCE COMPANY and ENTEX, INC.,
Defendants.

Jury Trial Requested

[Filed May 30, 1980]

COMPLAINT

TO THE HONORABLE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI:

Comes now the plaintiff, Everate W. Dedeaux, and would show unto the Court the following facts, to-wit:

COUNT I

TORTIOUS BREACH OF CONTRACT

I

That plaintiff is an adult resident citizen of the State of Mississippi, residing at Rt. 1, Box 369, Saucier, Mississippi.

That at all times herein mentioned, defendant, PILOT LIFE INSURANCE COMPANY, is a foreign corporation authorized to do business in the State of Mississippi, and that the registered agent for service of process is the Commissioner of Insurance for the State of Mississippi.

That at all times herein mentioned, defendant, ENTEX, INC., is a foreign corporation authorized to do business in the State of Mississippi, and that the registered agent for service of process is C T Corporation System, 118 N. Congress Street, Jackson, Mississippi 39205.

II

That at all times herein mentioned, defendants, and each of them, were the agents and employees of the other defendant, and were at all times acting within the purpose and scope of said agency and employment, and each defendant has ratified and approved the acts of his agent.

III

That prior to March, 1975, defendant, PILOT LIFE INSURANCE COMPANY, issued a group disability insurance policy to Entex, Inc., which provided disability benefits to the employees of Entex, Inc., being policy no. 7920 K. A copy of said written policy is in the possession of the defendants. Said insurance policy was entered into by plaintiff within the jurisdiction of the above entitled Court and required the payment of benefits within the jurisdiction of the above entitled Court in the amount of $463.63 per month for total disability.

IV

That plaintiff by and through his employer, Entex, Inc., has paid premiums due under said insurance policy to PILOT LIFE INSURANCE COMPANY at all relevant times herein and further, plaintiff has performed all obligations under said policy on plaintiff's part.

V

That on or about March 26, 1975, plaintiff was seriously injured, which injury has caused plaintiff serious, permanent and total disability, which disability has continued to the present time. Plaintiff was required to leave work due to his disability on March 26, 1975, and has not returned to work since that date.

VI

That plaintiff filed a claim for total disability benefits under said policy due to a total disability from said injury.

VII

That defendants, and each of them, have breached their duty of fair dealing and good faith owed to plaintiff in the following respects:

A. Failure to make disability payments to plaintiff at a time when defendants knew plaintiff was totally disabled and entitled to said benefits under said insurance policy.

B. Failure to pay full amount of benefits due the plaintiff.

C. Willfully and in bad faith withholding or delaying payments from plaintiff knowing plaintiff's claim for total disability benefits under said insurance policy to be valid.

D. Terminating plaintiff's benefits at a time when defendants had insufficient medical information or other information within their possession to justify such action.

E. Terminating plaintiff's benefits for total disability without interviewing plaintiff or requestng an independent medical examination of plaintiff or obtaining other information bearing upon plaintiff's total disability status.

F. Refusal to honor the claim of the plaintiff without a legitimate or arguable reason.

G. Refusal to honor the claim of the plaintiff for reasons contrary to the express provisions of the policy.

H. Willfully and in bad faith using the fact of the unequal wealth and bargaining position of the parties to effect economic gain for the defendant.

I. By other acts or omissions of defendant.

VIII

As a proximate result of the aforementioned wrongful conduct of defendants, plaintiff has suffered damages under the terms of the insurance policy in the amount of $463.63 per month for a total amount to be shown at the time of trial.

IX

As a further proximate result of the aforementioned wrongful conduct of the defendants, plaintiff has suffered anxiety, worry, mental and emotional distress and other incidental damages, all to plaintiff's general damage in the sum of $250,000.00.

X

Defendants have willfully and intentionally wronged the plaintiff or have treated the plaintiff with such gross and reckless negligence as is equivalent to such a wrong, entitling plaintiff to punitive damages in the sum of $500,000.00.

COUNT II

BREACH OF FIDUCIARY DUTIES

I

Plaintiff refers to each and every paragraph of the First Cause of Action and incorporates those paragraphs as though set forth in full in this cause of action.

II

By issuing said disability insurance policy to plaintiff and accepting premiums from him, defendants, PILOT LIFE INSURANCE COMPANY and ENTEX, INC., agreed and promised that if plaintiff became totally disabled, then the duty of defendants to pay benefits therefor would arise.

III

After plaintiff became totally disabled, he submitted a claim to defendants which gave rise to defendants' duty to pay benefits as herein alleged. After said duty to pay benefits arose, the sum of money attributable to said benefits was no longer the property of defendant, PILOT LIFE INSURANCE COMPANY, but was held by said defendant for the sole benefit and use of plaintiff, thereby creating a fiduciary relationship between defendant, PILOT LIFE INSURANCE COMPANY, and plaintiff.

IV

That defendants, and each of them, have breached their fiduciary duty to plaintiff by the acts or omissions set forth in the First Cause of Action, all to plaintiff's damage as set forth herein.

V

As a further proximate result of the aforementioned wrongful conduct of the defendants, plaintiff has suffered anxiety, worry, mental and emotional distress and other incidental damages, all to plaintiff's general damage in the sum of $250,000.00.

VI

That defendants, and each of them, have willfully and intentionally wronged the plaintiff or have treated the plaintiff with such gross and reckless negligence as is equivalent to such a wrong, entitling plaintiff to punitive damages in the sum of $500,000.00.

COUNT III

FRAUD IN THE INDUCEMENT

I

Plaintiff refers to each and every paragraph of the First Cause of Action and incorporates those paragraphs as though set forth in full in this cause of action .

II

That defendants, and each of them, made written and oral promises to plaintiff which were contained within the written and oral sales presentation made to plaintiff and within said insurance policy to pay plaintiff monthly disability benefits upon plaintiff becoming totally disabled and unable to work.

III

That defendants, and each of them, made said promises for the purpose of inducing plaintiff to rely upon said promises and to act in reliance upon them. Plaintiff relied upon said promises and paid premiums in reliance thereon.

IV

That defendants did not intend to perform said promises to plaintiff and made said promises with intent to defraud plaintiff. Plaintiff was unaware of defendants' intention not to perform and justifiably relied upon the promises made by defendant.

V

As a proximate result of plaintiff's reliance upon defendants' promises and defendants' intention not to perform said promises, plaintiff sustained damages as alleged:

1. Damages for failure to provide benefits under the insurance policy in a sum to be determined at the time of trial.

2. General damages for mental and emotional distress and other incidental damages in the sum of $250,000.00.

3. Punitive and exemplary damages in the sum of $500,000.00.

Respectfully submitted,

EVERATE W. DEDEAUX

By: DENTON & PERSONS

and

ROBERTS, STELLY & ROSETTI

By: /s/ William L. Denton
Of Counsel

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Attorneys for Plaintiff

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
THE SOUTHERN DIVISION

Civil Action No. S80-0467 (R)

EVERATE W. DEDEAUX,
Plaintiff

vs.

PILOT LIFE INSURANCE COMPANY and ENTEX, INC.,
Defendants

[Filed June 27, 1980]

ANSWER OF PILOT LIFE INSURANCE COMPANY TO COMPLAINT

FIRST DEFENSE

This Defendant states that the Complaint in Count I, Count II and Count III fails to state a claim against this Defendant upon which relief can be granted.

SECOND DEFENSE

COUNT I

1.

This Defendant admits the allegations of paragraph I of Count I.

2.

This Defendant denies the allegations of paragraph II of Count I.

3.

In answer to paragraph III of Count I, this Defendant admits the issuance of a group disability policy to Entex, Inc. bearing No. 7920 but would show that said policy speaks for itself. This Defendant denies the remaining allegations of said paragraph and denies that said policy provided for benefits alleged; and this Defendant would show that said policy provisions speak for themselves.

4.

This Defendant denies the allegations of paragraph IV of Count I.

5.

This Defendant denies the allegations of paragraph V of Count I.

6.

This Defendant admits the allegations of paragraph VI of Count I.

7.

This Defendant denies each and every allegation contained in paragraph VII of Count I and each and every allegation contained in sub-paragraphs A through I of said paragraph VII.

8.

This Defendant denies the allegations of paragraph VIII of Count I.

9.

This Defendant denies the allegations of paragraph IX of Count I.

10.

This Defendant denies the allegations of paragraph X of Count I and denies that Plaintiff is entitled to recover any amount whatsoever.

COUNT II

1.

This Defendant adopts and reiterates herein each and every denial contained in its answer to Count I of the Complaint.

2.

This Defendant denies the allegations of paragraph II of said Count II.

3.

This Defendant denies the allegations of paragraph III of said Count II.

4.

This Defendant denies the allegations of paragraph IV of said Count II.

5.

This Defendant denies the allegations of paragraph V of said Count II.

6.

This Defendant denies the allegations of paragraph VI of Count II and denies that Plaintiff is entitled to recover any amount whatsoever.

COUNT III

1.

This Defendant adopts and reiterates herein each and every denial contained in its answers to Counts I and II above.

2

This Defendant denies the allegations of paragraph II of Count III.

3.

This Defendant denies the allegations of paragraph III of Count III.

4.

This Defendant denies the allegations of paragraph IV of Count III.

5.

This Defendant denies the allegations of paragraph V of Count III and denies the allegations and demands contained in sub-paragraphs 1, 2 and 3 of paragraph V; also, this Defendant denies that Plaintiff is entitled to recover any amount whatsoever.

THIRD DEFENSE

1.

The policy certificate sued upon herein was issued under a group disability insurance policy to Entex, Inc. designated as Policy Number 7920. A copy of this policy certificate is attached hereto as Exhibit "A" and incorporated herein by reference. This policy certificate provides in part as follows:

"LONG TERM DISABILITY BENEFITS

If you become totally disabled as a result of injury or sickness while you are insured under the Group Policy for Long Term Disability Benefits, and if you are totally disabled for a period longer than the Elimination Period which applies to you, Pilot Life will pay the benefits described and limited in the following paragraphs.

Your Monthly Benefit, Elimination Period and Maximum Payment Period are determined from the Schedule of Insurance.

You will be considered totally disabled for the purpose of Long Term Disability Benefits

(a) during the first twenty-four months of any one period of total disability, only if you are continuously and completely prevented by injury or sickness from performing each and every duty of your occupation, and

(b) *after that twenty-four month period, only if you are continuously and completely prevented by injury or sickness from engaging in any and every occupation or employment for which you are reasonably fitted by education, training or experience.*

A 'period of total disability' shall be deemed to commence on the later to occur of

(a) the first day that you are totally disabled, and

(b) the thirty-first day immediately preceding the date you were, during the period of disability, first seen and treated personally by a legally qualified physician in connection with the disease or injury which caused such disability;

and the period of total disability shall be deemed to terminate on the earliest to occur of

(a) *the date you are no longer totally disabled;*

(b) *the date upon which you commence work at an occupation for which you are reasonably fitted by education, training or experience;*

(c) *the date you fail to furnish proof of the continuance of total disability, or refuse to be examined, when required by Pilot Life;*

(d) the date you cease to be under the care of a legally qualified physician;

(e) the date you attain the age of sixty-five years;

(f) the date of your death."

* * * *

"NOTICE AND PROOF OF CLAIM

All Benefits provided in the Group Policy shall be paid to you as they accrue upon receipt of written proof covering the occurrence, character and extent of the event for which claim is made.

> Affirmative proof of loss of time on account of disability must be furnished to Pilot Life within ninety days after the expiration of the Elimination Period. *Subsequent written proof of the continuance of such disability must be furnished to Pilot Life at such intervals at it may reasonably require.* [Emphasis added]

Plaintiff is entitled to no recovery in this action because his benefits were terminated in compliance with the above provisions in the group disability insurance policy. At the time that this Defendant terminated the disability benefits to Plaintiff he was no longer totally disabled under the terms of the policy, and Plaintiff is not so totally disabled at this time. Furthermore, this Defendant requested and gave Plaintiff an opportunity to have an additional examination by a specialist in order to enable him to furnish proof of the continuance of total disability, but Plaintiff refused to do so. This Defendant had credible information from reliable sources, including, but not limited to, information that Plaintiff was able to work and had been working prior to said termination, which required that it terminate benefits pursuant to the terms of the policy. Defendant had legitimate, allowable reasons for said termination, and has no liability herein for actual or punitive damages.

/s/ George F. Woodliff, III
SAM E. SCOTT
GEORGE F. WOODLIFF, III
1030 Capital Towers
Jackson, Mississippi 39201

Attorneys for Defendant,
Pilot Life Insurance Company

Of Counsel:

HEIDELBERG, WOODLIFF & FRANKS
1030 Capital Towers
Jackson, Mississippi 39201

CERTIFICATE OF SERVICE

I, George F. Woodliff, III, one of the attorneys of record for Defendant, Pilot Life Insurance Company, hereby certify that I have this day mailed a true and correct copy of the above and foregoing Answer of Pilot Life Insurance Company to Complaint, to DENTON & PERSONS, Post Office Box 1204, Biloxi, Mississippi 39533, and to ROBERTS, STELLY & ROSETTI, Post Office Drawer Y, Gulfport, Mississippi 39501, attorneys for Plaintiff.

This, the 26th day of June, 1980.

/s/ George F. Woodliff, III
GEORGE F. WOODLIFF, III

EXHIBIT "A"

UNITED GAS

GROUP

INSURANCE

CERTIFICATE

Group Long Term Disability Benefits

GROUP INSURANCE BOOKLET - CERTIFICATE

PILOT LIFE INSURANCE COMPANY
Greensboro, North Carolina

(which will be called Pilot Life in this booklet-certificate)
certifies that it has issued Group Policy Number 7920
to insure certain employees of

UNITED GAS, INC.

(which will be called the Policyholder in this
booklet-certificate)

The Group Policy is a contract between the Policyholder and Pilot Life which alone constitutes the agreement under which payments are made. It may be changed or terminated only by those parties. As of the date of its preparation, this booklet-certificate, together with any riders which may be attached to it, contains the principal provisions of the Group Policy affecting employees for whom this booklet-certificate was prepared. If the Group Policy is amended in a way which affects the insurance of employees, riders describing the amendment will be issued to be attached to this booklet-certificate, or a new booklet-certificate will be issued to replace this one.

When you have met the requirements for being insured under the Group Policy as shown on the following page, this booklet will become your certificate of insurance under the Group Policy.

/s/ Lewis C. Stephens, Jr.
President
PILOT LIFE INSURANCE COMPANY

This booklet-certificate was prepared on
September 4, 1973 3,000

BECOMING INSURED

WHO CAN BE INSURED

All full-time employees of the Policyholder who are less than sixty-four years and six months of age can be insured.

You will be considered a full-time employee if you have a regularly scheduled work week of thirty hours or more in the employ of the Policyholder.

The words you and your in this Booklet-Certificate refer to an employee in the classes eligible for insurance under the Group Policy.

WHEN YOU CAN BE INSURED

If you are a person who can be insured on September 1, 1973 you are eligible to be insured on that date. If you become a person who can be insured after that date, you will be eligible to be insured on the first day of the calendar month following the date you are employed or become a person who can be insured, whichever is the later date.

However, if you are an employee in a job classification represented for collective bargaining purposes, you will be eligible to be insured on September 1, 1973 or on the first day of the calendar month after you complete any probationary period negotiated with your employer, whichever is the later date.

WHEN YOUR INSURANCE BEGINS

If you are then actively-at-work for the Policyholder, your insurance will begin on the first day of the calendar month which is the same as or which next follows:

(a) the date you are first eligible to be insured if you have given the Policyholder a completed and signed enrollment card provided for that purpose on or before that date; or

(b) the date you give the Policyholder such a completed and signed enrollment card, if you do so after the date you are first eligible to be insured but no more than thirty-one days after that date; or

(c) the date on which Pilot Life approves your written request for insurance and evidence that you are insurable, if you make your written request to be insured more than thirty-one days after you are first eligible.

You will be considered actively-at-work for the purpose of having your insurance begin only if you are performing the regular duties of your employment on a full-time basis, either at one of the Policyholder's regular places of business or at some location to which you are required to travel to do your work. If you are not actively-at-work when your insurance would otherwise begin, it will begin on the next day you are actively-at-work.

WHEN YOUR INSURANCE ENDS

Your insurance under the Group Policy will end on the earliest of the following dates:

(a) the date the Group Policy terminates or is amended to terminate the insurance for the class of employees to which you belong;

(b) the date which precedes your 65th birthday by a period equal to the elimination period which applies to you according to the Schedule of Insurance; or

(c) the date your active employment with the Policyholder ends; however, your active employment with the policy holder will be considered to continue (and your insurance will be continued) dur-

ing any period you are absent from work on account of injury or sickness, leave of absence or temporary lay-off if the Policyholder, acting on a non-discriminatory basis, continues premium payments on account of your insurance but not for longer periods than those set out in the Group Policy.

If you must be absent from active work for any reason, you should ask the Policyholder what arrangements, if any, can be made for continuing your insurance.

SCHEDULE OF INSURANCE

BENEFITS FOR YOU

Long Term Disability Benefits	Amount of Insurance
Monthly Benefit	60% of your Basic Monthly Salary Rate *, but not more than $1,500

Elimination Period—six months

Maximum Payment Period—the period ending on the last day of the calendar month during which your sixty-fifth birthday occurs

Coordination With Other Income

Your Monthly Benefit will be coordinated with income from any of the following sources:

SOURCE A

1. 50% of the amount of any remuneration you receive for work performed in connection with an approved rehabilitation program,
2. the amount of any remuneration you receive from an employer, and the amount you receive from any occupation or compensation or profit; excluding, however, for the purposes of this item (2), any such amount attributable to an approved rehabilitation program,

3. any payment under any profit sharing plan of your employer, but only to the extent that such payment, solely by reason of your disability, exceeds the payment you would have received had you not become disabled and had you terminated employment or withdrawn from such plan as of the date service ceases to be credited to you under such plan,
4. any periodic cash payments to which the insured person, or any of his dependents, is entitled under any retirement plan or plans covering employees of the group Policyholder,
5. any payment with respect to disability under any group life insurance policy (whether issued by Pilot Life or any other insurer),
6. any payment under any unemployment compensation law or under any other arrangement for payments on account of unemployment,
7. Any payment, for disability, by reason of your past or present service in the armed forces of a government; provided, however, that if the disability commenced prior to the effective date of your insurance under the group policy, only that part of any such payment which results from an increase in the level of payments commencing on or after the effective date of your insurance and which is attributable to an increase in the degree of disability, shall be taken into account, for the purposes of this item (7), and
8. any payment by reason of early retirement, other than because of disability, including any benefits to which you or your spouse, child or dependent is entitled by reason of your retirement, under the Federal Social Security Act, the Railroad Retirement Act, or any similar act of any national government; and

SOURCE B (See provisions in Notice And Proof of Claim section relating to SOURCE B income)

1. the amount of any benefit provided with respect to a disability,

   (a) under any group insurance plan or any other arrangement of coverage for individuals as a group, whether on an insured or uninsured basis, and

   (b) under any fund or other arrangement, pursuant to any compulsory benefit act or law, and

2. any payment for a disability which commenced on or after the effective date of your insurance under the group policy, under the Federal Social Security Act or Railroad Retirement Act, or any similar act of any national government, or by any federal, state, provincial, municipal or other governmental agency or pursuant to any workmen's compensation law, occupational disease law, or any other legislation of similar purposes, or the maritime doctrine of maintenance, wages, and cure. For the purposes of this item (2), there shall be included any benefits to which you or a dependent is entitled by reason of your disability.

Coordinated Benefit Maximum — 60% of your Basic Monthly Salary Rate *, but not more than $1,500

However, if your Monthly Benefit is coordinated with income from any of the above sources, in no event shall the amount of Monthly Benefit actually payable by Pilot Life be less than 20% of your Basic Monthly Salary Rate *

For the purposes of determining income from other sources, any single sum payment and any periodic payments shall be allocated by Pilot Life to monthly periods, and any single sum payment or periodic payment, regardless of whether such payment is or is not the result of a compromise, award or judgment shall be considered, for the purposes of insurance hereunder, to be paid monthly.

* Basic monthly salary rate means your basic rate of compensation by the policyholder at the commencement of the period of total disability computed on a monthly basis, exclusive of any commissions, bonus, overtime, or incentive pay.

However, if you are compensated on a Commission Basis, your "Basic Monthly Salary Rate" means the monthly average of your earnings with the Policyholder (including salary and commissions, but excluding any overtime, bonus or other incentive pay) as determined each month by the Policyholder based on your earnings during the shorter of (a) the period of twelve months preceding the date of such determination, and (b) the period of your employment with the Policyholder.

LONG TERM DISABILITY BENEFITS

If you become totally disabled as a result of injury or sickness while you are insured under the Group Policy for Long Term Disability Benefits, and if you are totally disabled for a period longer than the Elimination Period which applies to you, Pilot Life will pay the benefits described and limited in the following paragraphs.

Your Monthly Benefit, Elimination Period and Maximum Payment Period are determined from the Schedule of Insurance.

You will be considered totally disabled for the purpose of Long Term Disability Benefits

(a) during the first twenty-four months of any one period of total disability, only if you are continuously and completely prevented by injury or

sickness from performing each and every duty of your occupation, and

(b) after that twenty-four month period, only if you are continuously and completely prevented by injury or sickness from engaging in any and every occupation or employment for which you are reasonably fitted by education, training or experience.

A "period of total disability" shall be deemed to commence on the later to occur of

(a) the first day that you are totally disabled, and

(b) the thirty-first day immediately preceding the date you were, during the period of disability, first seen and treated personally by a legally qualified physician in connection with the disease or injury which caused such disability;

and the period of total disability shall be deemed to terminate on the earliest to occur of

(a) the date you are no longer totally disabled;

(b) the date upon which you commence work at an occupation for which you are reasonably fitted by education, training or experience;

(c) the date you fail to furnish proof of the continuance of total disability, or refuse to be examined, when required by Pilot Life;

(d) the date you cease to be under the care of a legally qualified physician;

(e) the date you attain the age of sixty-five years;

(f) the date of your death.

BENEFITS FOR TOTAL DISABILITY

For any one period of total disability which begins while you are insured, Pilot Life will pay one-thirtieth of your

Monthly Benefit for each day of total disability after the expiration of the Elimination Period and before the expiration of the Maximum Payment Period which applies to you.

REHABILITATION

Pilot Life shall retain the right to evaluate you for rehabilitation to any occupation for which you may be, or may reasonably become fitted by education, training, or experience. If, in the judgment of Pilot Life, you are able to undertake to successfully rehabilitate you, Pilot Life may, in its sole discretion and with your consent undertake such rehabilitation. Pilot Life will be responsible for the payment of the charges for all services and supplies in connection with an approved rehabilitation program.

"Approved rehabilitation program" means only

(a) a program of vocational rehabilitation, whether formal or informal, or

(b) a period of part-time work for purposes of rehabilitation,

Which Pilot Life approves in writing, and which shall be considered to begin only when Pilot Life gives its approval thereto and to end when such approval is withdrawn.

REDUCTIONS IN AMOUNT OF MONTHLY BENEFITS

(Coordination With Other Income)

If you receive (or are entitled to receive by making proper application for it) payment from any of the sources listed under Coordination With Other Income in the Schedule of Insurance for any period for which you are entitled to Long Term Disability Benefits, the amount of your Monthly Benefits otherwise provided for that period will be reduced, if necessary, so that the total of your Monthly Benefits and the payments from such other

sources will not exceed the Coordinated Benefit Maximum shown in the Schedule of Insurance.

RECURRENT DISABILITIES

If, within six months after recovery from any period of disability commencing when you are insured under the Group Policy and while you are still insured under the Group Policy, you again become totally disabled from the same or any related cause or causes, such disability will be considered a continuation of the previous period of disability; otherwise, any subsequent period of disability will be considered a new period of disability. In no event, however, will Long Term Disability Benefits be paid for disability involving two or more periods of total disability which are due to the same or any related cause or causes and are separated by less than six months unless you are totally disabled for longer than the Elimination Period during a period of not more than twenty-four consecutive months.

EXCLUSIONS

Benefits will not be paid for any period of disability caused by or resulting from

(a) pregnancy or resulting childbirth or complications;

(b) injury or sickness for which you were treated by any physician or other practitioner or for which you took prescription drugs or medicines during the three month period immediately preceding the effective date of your Long Term Disability Benefits unless such period of disability commences after a period of at least twelve consecutive months during which you took no prescription drugs or medicines and received no treatment by a physician or other practitioner on account of such injury or sickness;

(c) injuries intentionally self-inflicted, while sane or insane (in Missouri, while sane);

(d) participating in a riot or committing, or attempting to commit, an assault or a felony; or

(e) war or any act of war, including armed aggression resisted by the armed forces of any country, combination of countries or international organization, whether or not war is declared.

EXTENSION OF BENEFITS

If, during a period of total disability which commenced while you were insured for Long Term Disability Benefits, your insurance terminates, Long Term Disability Benefits will continue during the continuance of that period of total disability until terminated in accordance with other provisions of the Group Policy.

HOW TO CLAIM BENEFITS

You can get the forms you need for claiming benefits from the office of the Policyholder. You can also get help in completing the forms. When forms are properly completed return them to the Policyholder so they can be sent to Pilot Life as soon as possible.

NOTICE AND PROOF OF CLAIM

All Benefits provided in the Group Policy shall be paid to you as they accrue upon receipt of written proof covering the occurrence, character and extent of the event for which claim is made.

Affirmative proof of loss of time on account of disability must be furnished to Pilot Life within ninety days after the expiration of the Elimination Period. Subsequent written proof of the continuance of such disability must be furnished to Pilot Life at such intervals as it may reasonably require.

Failure to furnish proof within the time provided in this certificate shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

No action at law or in equity shall be brought to recover on the Group Policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this certificate, nor shall such action be brought at all unless brought within six years from the expiration of the time within which proof of loss is required by this certificate.

Pilot Life shall have the right to require as part of the proof of claim satisfactory evidence (a) that you have made application for all Source B income referred to in this Certificate, (b) that you have furnished all required proofs for such benefits, (c) that you have not subsequently waived such benefits, and (d) of the amount of all Source A and Source B income payable.

Pilot Life shall have the right and opportunity to examine the person whose injury or sickness is the basis of claim when and so often as it may reasonably require during the pendency of claim under the Group Policy.

PAYMENT OF CLAIMS

Subject to proof of claim, all accrued benefits under the group policy will, except as otherwise specifically provided, be paid at the end of each calendar month during the period for which benefits are payable hereunder, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof. Benefits are payable to you.

If any benefit under the group policy is payable to your estate, or if you are a minor or otherwise not competent to give a valid release, Pilot Life may pay such benefit up to an amount not exceeding $1,000 to your relative by blood or connection by marriage who is deemed by Pilot Life to be equitably entitled thereto. Any payment made by Pilot Life in good faith pursuant to this provision will fully discharge Pilot Life's obligation to the extent of such payment.

[SEAL]

PILOT
LIFE

Underwritten by

PILOT LIFE INSURANCE COMPANY

Greensboro, North Carolina

[SEAL]

PILOT LIFE

RIDER No. 1

Rider to be attached to
and made a part of Group Policy No. 7920

issued to UNITED GAS, INC.

In accordance with the written request of the Policyholder, effective April 4, 1974 the above described policy is hereby amended by substituting for the name of the Policyholder whenever it appears in the policy, the following:

"Entex, Inc."

All Booklet-Certificates issued under said Group Policy shall have the same force and effect as if the name of the Policyholder were shown as last indicated above on such Booklet-Certificates.

Any provisions of the Group Policy inconsistent with the terms of this Rider are hereby declared void and of no effect.

Nothing contained in this Rider shall be construed to alter or amend any provisions of the Group Policy except as specifically provided herein.

May 2, 1974

PILOT LIFE INSURANCE COMPANY

/s/ W. Linville Roach
Secretary

/s/ [Illegible]
Registrar

[SEAL]

PILOT LIFE

RIDER No. 2

Rider to be attached to
and made a part of Group Policy No. 7920

issued to ENTEX, INC.

In accordance with the written request of the Policyholder, effective October 1, 1975 the above described policy is hereby amended by adding to the Booklet-Certificate attached to and incorporated into the said policy the attached Booklet-Certificate Rider.

Any provisions of the Group Policy inconsistent with the terms of this Rider are hereby declared void and of no effect.

Nothing contained in this Rider shall be construed to alter or amend any provisions of the Group Policy except as specifically provided herein.

November 20, 1975

PILOT LIFE INSURANCE COMPANY

/s/ W. Linville Roach
Secretary

/s/ [Illegible]
Registrar

BOOKLET—CERTIFICATE(S) AND RIDER(S) INCORPORATED IN THIS POLICY

[SEAL]

PILOT LIFE INSURANCE COMPANY

Greensboro, North Carolina

BOOKLET-CERTIFICATE RIDER

Rider to a Booklet-Certificate describing certain provisions of Group Policy No. 7920

issued to

ENTEX, INC.

And in accordance with an amendment to said policy effective Octboer 1, 1975 the Schedule of Insurance in your Booklet-Certificate is amended:

(1) by substituting for the Monthly Benefit under "Long Term Disability Benefits", the following:

"Monthly Benefit	60% of your Basic Monthly Salary Rate *, but not more than $3,500";

(2) by substituting for item 8. under "Coordination With Other Income—SOURCE A", the following:

"8. any payment by reason of early retirement, other than because of disability, including any benefits to which you or your spouse, child or dependent is entitled by reason of your retirement, under the Federal Social Security Act (excluding any increases other than increases due to a change in your family status in the amount of such payments made after the initial determination of the monthly amount of your Social Security disability benefit), the Railroad

Retirement Act, or any similar act of any national government; and";

The provisions on the reverse side are part of this rider.

Those parts of the Booklet-Certificate not in conflict with this Rider are not changed by this Rider.

/s/ L. Stephens, Jr.
President

11-75 3,000

—

(3) by substituting for item 2. under "Coordination With Other Income—SOURCE B", the following:

"2. any payment for a disability which commenced on or after the effective date of your insurance under the policy, under the Federal Social Security Act (excluding any increases other than increases due to a change in your family status in the amount of such payments made after the initial determination of the monthly amount of your Social Security disability benefit) or Railroad Retirement Act, or any similar act of any national government, or by any federal, state, provincial, municipal or other governmental agency or pursuant to any workmen's compensation law, occupational disease law, or any other legislation of similar purposes, or the maritime doctrine of maintenance, wages, and cure. For the purposes of this item (2) there shall be included any benefits to which you or a dependent is entitled by reason of your disability."; and

4. by substituting for the "Coordinated Benefit Maximum", the following:

"Coordination Benefit Maximum

60% of your Basic Monthly Salary Rate *, but not more than $3,500."

If you are not actively-at-work on the date this Rider would otherwise become effective on your account, such Rider shall not become effective until the date of your return to active, full-time work.

Group Policy No. 7920
11-75 3,000

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
THE SOUTHERN DIVISON

Civil Action No. S80-0467(R)

EVERATE W. DEDEAUX,
Plaintiffs

vs.

PILOT LIFE INSURANCE COMPANY AND ENTEX, INC.,
Defendants

ANSWER OF ENTEX, INC.

COMES NOW, ENTEX, INC., Defendant in the above styled cause, and files this its answer to the Complaint in the above entitled cause as follows:

FIRST AFFIRMATIVE DEFENSE

The Complaint fails to state a claim against Entex, Inc. upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

The Plaintiff's claim is barred by the applicable Statute of Limitations.

And now, having set forth affirmative defenses to the Complaint in this cause, Entex, responds to the separate numbered paragraphs in the Complaint as follows:

COUNT I

I.

Entex, Inc. admits the allegations in Paragraph I of Count I of the Complaint.

II.

Entex, Inc. denies the allegations in Paragraph II of Count I of the Complaint.

III.

Entex, Inc. admits the issuance of group disability policy No. 7920 K and denies the remaining allegations of Paragraph III of Count I of the Complaint.

IV.

Entex, Inc. denies the allegations of Paragraph IV of Count I of the Complaint.

V.

Entex, Inc. denies the allegations of Paragraph V of Count I of the Complaint.

VI.

Entex, Inc. admits the allegations of Paragraph VI of Count I of the Complaint.

VII.

Entex, Inc. denies the allegations of Paragraph VI of Count I of the Complaint and each and every allegation contained in Sub-Paragraphs A-I of said Paragraph VII.

VIII.

Entex, Inc. denies the allegations of Paragraph VIII of Count I of the Complaint.

IX.

Entex, Inc. denies the allegations of Paragraph IX of Count I of the Complaint.

X.

Entex, Inc. denies the allegations of Paragraph X of Count I of the Complaint and denies that Plaintiff is entitled to relief prayed for, or any relief whatever.

COUNT II

I.

Entex, Inc. adopts and realleges herein each and every denial contained in its answer to Count I of the Complaint.

II.

Entex, Inc. denies the allegations of Paragraph II of Count II of the Complaint.

III.

Entex, Inc. denies the allegations of Paragraph III of Count II of the Complaint.

IV.

Entex, Inc. denies the allegations of Paragraph IV of Count II of the Complaint.

V.

Entex, Inc. denies the allegations of Paragraph V of Count II of the Complaint.

VI.

Entex, Inc. denies the allegations of Paragraph VI of Count II of the Complaint and specifically denies that Plaintiff is entitled to the relief prayed for, or any relief whatever.

COUNT III

I.

Entex, Inc. adopts and realleges herein each and every denial contained in its answers to Counts I and II above.

II.

Entex, Inc. denies the allegations of Paragraph II of Count III of the Complaint.

III.

Entex, Inc. denies the allegations of Paragraph III of Count III of the Complaint.

IV.

Entex, Inc. denies the allegations of Paragraph IV of Count III of the Complaint.

V.

Entex, Inc. denies the allegations of Paragraph V of Count III of the Complaint and denies the allegations and demands contained in Sub-Paragraphs 1, 2 and 3 of Paragraph V; further, Entex, Inc. denies that the Plaintiff is entitled to the relief prayed for, or any relief whatever.

Respectfully submitted, this the 14th day of July, 1980.

ENTEX, INC.

By: /s/ Christopher A. Shapley
CHRISTOPHER A. SHAPLEY
Its Attorney

Of Counsel:

BRUNINI, GRANTHAM, GROWER & HEWES
1440 First National Bank Building
P. O. Drawer 119
Jackson, Mississippi 39205
(601) 948-3101

CERTIFICATE OF SERVICE

I, Christopher A. Shapley, attorney of record for Defendant, Entex, Inc., hereby certify that I have this day mailed a true and correct copy of the above and foregoing Answer of Entex, Inc. to William L. Denton, Esq., Denton & Persons, Post Office Box 1204, Biloxi, Mississippi 39533; and Roberts, Stelly & Rosetti, Post Office Drawer Y, Gulfport, Mississippi 39501, attorneys for Plaintiff.

This the 14 day of July, 1980.

/s/ Christopher A. Shapley
CHRISTOPHER A. SHAPLEY

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

Civil Action No. S80-0467 (R)

EVERATE W. DEDEAUX,
Plaintiff

vs.

PILOT LIFE INSURANCE COMPANY and ENTEX, INC.,
Defendants

[Filed Aug. 6, 1982]

AMENDED ANSWER AND COUNTERCLAIM OF PILOT LIFE INSURANCE COMPANY TO COMPLAINT

FIRST DEFENSE

This Defendant states that the Complaint in Count I, Count II and Count III fails to state a claim against this Defendant upon which relief can be granted.

SECOND DEFENSE

COUNT I

1.

This Defendant admits the allegations of paragraph I of Count I.

2.

This Defendant denies the allegations of paragraph II of Count I.

3

In answer to paragraph III of Count I, this Defendant admits the issuance of a group disability policy to Entex, Inc. bearing No. 7920 but would show that said policy speaks for itself. This Defendant denies the remaining allegations of said paragraph and denies that said policy provided for the benefits alleged; and this Defendant would show that said policy provisions speak for themselves.

4.

This Defendant denies the allegations of paragraph IV of Count I.

5.

This Defendant denies the allegations of paragraph V of Count I.

6.

This Defendant admits the allegations of paragraph VI of Count I.

7.

This Defendant denies each and every allegation contained in paragraph VII of Count I and each and every allegation contained in sub-paragraphs A through I of said paragraph VII.

8.

This Defendant denies the allegations of paragraph VIII of Count I.

9.

This Defendant denies the allegations of paragraph IX of Count I.

10.

This Defendant denies the allegations of paragraph X of Count I and denies that Plaintiff is entitled to recover any amount whatsoever.

COUNT II

1.

This Defendant adopts and reiterates herein each and every denial contained in its answer to Count I of the Complaint.

2.

This Defendant denies the allegations of paragraph II of said Count II.

3.

This Defendant denies the allegations of paragraph III of said Count II.

4.

This Defendant denies the allegations of paragraph IV of said Count II.

5.

This Defendant denies the allegations of paragraph V of said Count II.

6.

This Defendant denies the allegations of paragraph VI of Count II and denies that Plaintiff is entitled to recover any amount whatsoever.

COUNT III

1.

This Defendant adopts and reiterates herein each and every denial contained in its answers to Counts I and II above.

2.

This Defendant denies the allegations of paragraph II of Count III.

3.

This Defendant denies the allegations of paragraph III of Count III.

4.

This Defendant denies the allegations of paragraph IV of Count III.

5.

This Defendant denies the allegations of paragraph V of Count III and denies the allegations and demands contained in sub-paragraphs 1, 2 and 3 of paragraph V; also, this Defendant denies that Plaintiff is entitled to recover any amount whatsoever.

THIRD DEFENSE

1.

The policy certificate sued upon herein was issued under a group disability insurance policy to Entex, Inc. designated as Policy Number 7920. A copy of this policy certificate is attached hereto as Exhibit "A" and incorporated herein by reference. This policy certificate provides in part as follows:

> "LONG TERM DISABILITY BENEFITS
>
> If you become totally disabled as a result of injury or sickness while you are insured under the Group Policy for Long Term Disability Benefits, and if you are totally disabled for a period longer than the Elimination Period which applied to you, Pilot Life will pay the benefits described and limited in the following paragraphs.
>
> Your Monthly Benefit, Elimination Period and Maximum Payment Period are determined from the Schedule of Insurance.
>
> *You will be considered totally disabled for the purpose of Long Term Disability Benefits*
>
> (a) during the first twenty-four months of any one period of total disability, only if you are

continuously and completely prevented by injury or sickness from performing each and every duty of your occupation, and

(b) *after that twenty-four month period, only if you are continuously and completely prevented by injury or sickness from engaging in any and every occupation or employment for which you are reasonably fitted by education, training or experience.*

A 'period of total disability' shall be deemed to commence on the later to occur of

(a) the first day that you are totally disabled, and

(b) the thirty-first day immediately preceding the date you were, during the period of disability, first seen and treated personally by a legally qualified physician in connection with the disease or injury which caused such disability;

and the period of total disability shall be deemed to terminate on the earliest to occur of

(a) *the date you are no longer totally disabled;*

(b) *the date upon which you commence work at an occupation for which you are reasonably fitted by education, training or experience;*

(c) *the date you fail to furnish proof of the continuance of total disability, or refuse to be examined, when required by Pilot Life;*

(d) the date you cease to be under the care of a legally qualified physician;

(e) the date you attain the age of sixty-five years;

(f) the date of your death."

* * * *

"NOTICE AND PROOF OF CLAIM

All Benefits provided in the Group Policy shall be paid to you as they accrue upon receipt of written proof covering the occurence, character and extent of the event for which claim is made.

Affirmative proof of loss of time on account of disability must be furnished to Pilot Life within ninety days after the expiration of the Elimination Period. *Subsequent written proof of the continuance of such disability must be furnished to Pilot Life at such intervals as it may reasonably require*" [Emphasis added]

Plaintiff is entitled to no recovery in this action because his benefits were terminated in compliance with the above provisions in the group disability insurance policy. At the time that this Defendant terminated the disability benefits to Plaintiff he was no longer totally disabled under the terms of the policy, and Plaintiff is not so totally disabled at this time. Furthermore, this Defendant requested and gave Plaintiff an opportunity to have an additional examination by a specialist in order to enable him to furnish proof of the continuance of total disability, but Plaintiff refused to do so. This Defendant had credible information from reliable sources, including, but not limited to, information that Plaintiff was able to work and had been working prior to said termination, which required that it terminate benefits pursuant to the terms of the policy. Defendant had legitimate, arguable reasons for said termination, and has no liability herein for actual or punitive damages.

FOURTH DEFENSE

The Complaint in Count I, Count II and Count III is preempted by 29 USCA §§ 1001 *et seq.* and specifically by 29 USCA § 1132 and § 1144 which provide for Plaintiff's exclusive remedy in this case.

COUNTERCLAIM

1.

This Defendant incorporates herein as though fully rewritten all of the allegations contained in its Third Defense of its Amended Answer. On August 28, 1981, Mr. David A. Mitchell, Second Vice President and Counsel of this Defendant, resumed the payment of disability benefits to Plaintiff by letter of that date. A copy of that letter is attached hereto as Exhibit "B" and incorporated herein by reference. Enclosed with that letter was this Defendant's check made payable to Plaintiff in the amount of $4,921.27 which represented benefits from March 24, 1980, to August 24, 1981, the period of time for which benefits had not been paid. That letter explained the reason for the resumption of payments and also the reason for the delay in the resumption.

2.

Since August 28, 1981, this Defendant has made monthly disability payments to Plaintiff pursuant to the terms of the policy.

3.

Since the resumption of these payments, additional information has come to this Defendant that Plaintiff is not now totally disabled within the terms of the subject policy and has not been so totally disabled at least since 1979.

4.

As a result of the uncertainty caused by the litigation, this Defendant has continued to make disability payments to Plaintiff pursuant to the policy, but desires a declaratory judgment that Plaintiff is not now totally disabled under the terms of the subject policy and has not been so disabled since March, 1980.

5.

If the Court renders a declaratory judgment in this Defendant's favor that Plaintiff has not been totally disabled under the terms of the subject policy since March, 1980, this Defendant demands recovery from Plaintiff of all disability payments which have been made covering the period from March 24, 1980, to date.

WHEREFORE, this Defendant demands judgment against Plaintiff as follows:

(1) Under the Declaration, judgment in its favor and against Plaintiff.

(2) Under this Defendant's Counterclaim, judgment declaring that Plaintiff is not now totally disabled under the terms of the subject policy and has not been so disabled since March, 1980, and recovery from Plaintiff of all disability payments made by this Defendant covering the period from March 24, 1980, to date.

(3) Such further relief as the Court deems proper.

(4) This Defendant's costs herein.

Heidelberg, Woodliff & Franks
Attorneys for Defendant,
Pilot Life Insurance Company

/s/ George F. Woodliff, III
Sam E. Scott
George F. Woodliff, III
1030 Capital Towers
Jackson, Mississippi 39201

Of Counsel:

Heidelberg, Woodliff & Franks
1030 Capital Towers
Jackson, Mississippi 39201
Telephone: (601) 948-3800

CERTIFICATE OF SERVICE

I, GEORGE F. WOODLIFF, III, one of the attorneys of record for Defendant, Pilot Life Insurance Company, hereby certify that I have mailed a true and correct copy of the foregoing Amended Answer and Counterclaim of Pilot Life Insurance Company to Complaint, to all of the attorneys of record, as follows: Messrs. Denton & Persons, Post Office Box 1204, Biloxi, Mississippi 39533 and Messrs. Roberts, Stelly & Rosetti, Post Office Drawer Y, Gulfport, Mississippi 39501, attorneys for Plaintiff, and Christopher A. Shapley, Esquire, Post Office Drawer 119, Jackson, Mississippi, 39205, attorney for Defendant, Entex, Inc.

THIS, the 5th day of August, 1982.

/s/ George F. Woodliff, III
GEORGE F. WOODLIFF, III

EXHIBIT A is reproduced at pages 32 to 50 of the Joint Appendix.

EXHIBIT "B"

Pilot Life
Insurance Company
PO Box 20727
Greensboro NC 27420
Telephone Bus 919 299 4720

[SEAL]

PILOT
LIFE

August 28, 1981

Mr. William L. Denton
Denton & Persons, P.A.
1039 West Howard Avenue
Biloxi, Mississippi 39533

Re: Everate Dedeaux vs Pilot Life Insurance Company

Dear Mr. Denton:

Following our recent meeting in Biloxi, I reported to our Claims Committee, and the Claims Committee after careful deliberation, has decided that Mr. Dedeaux's claim for benefits should be brought up to date at this time. Therefore, enclosed is Pilot's check No. AO1 019663 in the amount of $4,921.27 made payable to Everate Dedeaux which you will want to deliver to him. Attached to the check is a copy of the worksheet showing how the payment was calculated. This check represents benefits from March 24, 1980, to August 24, 1981. You will note that we have coordinated with Workmen's Compensation. Mr. Dedeaux's certificate booklet at the top of page 6 specifically provides for coordination with single sum payments such as Mr. Dedeaux received from Workmen's Compensation.

Neither this payment nor any payment that may be made in the future can be construed in any way as an admission on the part of Pilot Life that Mr. Dedeaux's claim is payable, nor can it be construed as a waiver of any of Pilot Life's defenses in the pending litigation.

Pilot Life expressly reserves all of its defenses in this case.

The action of Pilot Life in resuming the payment of these benefits is partially taken for the convenience of Mr. Dedeaux so as to avoid any undue hardship for him during the pendency of the litigation. The other reason for the resumption of the payment of benefits is the proof of disability that was furnished to the company in the form of letters from Dr. James Tanner and Dr. Lloyd W. Russell. The following chronology of events will explain why the payments were not resumed immediately upon receipt of these letters.

The company had paid benefits to Mr. Dedeaux up to March 24, 1980, at which time we discontinued paying benefits upon our determination, based upon the facts available to us, that Mr. Dedeaux was no longer entitled to them. At that time, Mr. Dedeaux was represented by Herbert J. Stelly, Jr., and on March 14, 1980, we mailed to Mr. Stelly the benefit check for the period ending March 24, 1980. In our letter to Mr. Stelly, we informed him of our decision but we also told Mr. Stelly that if he felt that Mr. Dedeaux continued to be totally disabled, we would be happy to refer Mr. Dedeaux to Dr. Henry La Rocca in New Orleans for further evaluation. We indicated that this would, of course, be at our expense. We received no response from Mr. Stelly. We also requested Mr. Stelly to furnish us a copy of Mr. Dedeaux's most recent Social Security decision, and this we have never received.

Suit was filed by you in May 1980, with an Answer date of June 19, 1980. I visited with you in your office on July 17, 1980, for the purpose of attempting to negotiate a settlement in this case. At that time you agreed that this case should be settled, and I offered an amount in settlement. You stated that you would review the case with your client and that after you had met with him, you would come forth with a reasonable settlement offer.

Any actions that we have taken since the time of that meeting have been taken in anticipation that you would proceed promptly with the good faith negotiations.

On September 25, 1980, I received a letter from you to which was attached the letter from Dr. Lloyd W. Russell dated June 30, 1980, addressed to Dr. James Tanner, and the letter from Dr. James C. Tanner dated August 11, 1980, addressed to whom it may concern. On October 1, 1980 my legal assistant intended to send copies of these letters to our attorney, but inadvertently addressed the cover letter to you. Copies of these letters were eventually mailed to our attorney on October 21, 1980. On October 29, 1980, we received information from our attorney that he had discussed the matter with you and that you had told him that you would give him a settlement figure in the near future.

Our Claims Committe reviewed the case and specifically the letters from Dr. Tanner and Dr. Russell on October 30, 1980. At this meeting of the Claims Committee, I discussed with the committee the advisability at that time, based upon the letters from the two doctors, of bringing Mr. Dedeaux's claim for benefits up to date. Inasmuch as all indications were that you still desired a settlement, I thought that the entire matter could be concluded in the very near future. If I had anticipated in any way that this case would not have been settled quite promptly, the benefit payments would have been resumed at that time.

After having waited many months to receive a settlement offer from you, we were finally able to set up another meeting in Biloxi. You again indicated your desire to settle the case for a lump sum rather than to have Mr. Dedeaux receive monthly benefits. You stated that you would discuss our settlement offer with Mr. Dedeaux and that you would call me with his response. We later received your letter rejecting our offer.

We hope that you understand our position and realize that we are not being critical of you. We simply expected to hear back from you much sooner than we did, and this is the reason for the delay in the resumption of the payment of the benefits.

The continued payment of disability benefits will depend upon Pilot Life receiving from Mr. Dedeaux the following information:

1. The most recent Social Security decision;
2. Evidence that Mr. Dedeaux has not ceased to be under the care of a legally qualified physician;
3. A current certification of disability from Mr. Dedeaux's physician;
4. Where Mr. Dedeaux is now residing.

In addition, it may be necessary for Mr. Dedeaux to undergo another medical examination. This, of course, will be at Pilot Life's own expense.

Sincerely yours,

/s/ David A. Mitchell
DAVID A. MITCHELL
Second Vice President
and Counsel

DAM:pm

Enclosure

Pilot Life

PILOT LIFE INSURANCE COMPANY

GREENSBORO, NORTH CAROLINA

EXTENDED DISABILITY PAYMENTS

POLICYHOLDER ______ INSURED ______

YOUR EXTENDED DISABILITY BENEFITS POLICY PROVIDES A MONTHLY DISABILITY BENEFIT FOR INSUREDS THAT ARE TOTALLY DISABLED FOR A PERIOD OF TIME THAT EXCEEDS THE ELIMINATION PERIOD. THE AMOUNT OF THE MONTHLY BENEFIT IS BASED ON A PERCENTAGE OF THE BASIC MONTHLY SALARY OF THE INSURED, AND IS COMPUTED IN THE FOLLOWING MANNER:

THE BENEFIT COMPUTATION: TO DETERMINE THE BENEFITS PROVIDED BY THE PLAN

REGULAR BENEFITS: ______ % of the basic monthly salary
(Payable when insured has no other disability coverage)

BASIC SALARY: $ 772.72

x 60 %

REGULAR MONTHLY BENEFIT $ 463.63

COORDINATED BENEFITS: ______ % of salary, less other coverage
(Payable when other disability coverage exists (Social Security, Workmens Compensation, other disability insurance, Salary continued, etc.)

BASIC SALARY: $ 772.72

x 60 %

$ 463.63 NET COVERED AMOUNT

less $ ______ SOCIAL SECURITY

less $ 273.00 WORKMENS COMPENSATION

less $ ______ ______

COORDINATED MONTHLY BENEFIT $ 190.63

THE PAYMENT COMPUTATION: TO DETERMINE THE PAYMENTS TO BE MADE FOR THE CLAIM THAT WAS SUBMITTED

DATE DISABLED: ______ ELIMINATION PERIOD: ______

PAY FROM 2-20-81 TO 8-24-81 at the REGULAR BENEFIT of $ 463.63 per month, which is:

6 MONTHS at $ 463.63 = 2781.78
WEEKS at $ ______ = ______
4 DAYS at $ ______ = 61.77

= TOTAL REGULAR PAYMENT OF $ 2843.55

4921.27

PAY FROM 3-24-80 TO 2-20-81 at the COORDINATED BENEFIT of $ 190.63 per month, which is:

10 MONTHS at $ 190.63 = 1906.30
WEEKS at $ ______ = ______
27 DAYS at $ ______ = 171.42

= TOTAL COORDINATED PAYMENT OF $ 2077.72

ACCUMULATION ______

OTHER INFORMATION: THE FOLLOWING ITEM(S) ARE BEING REQUESTED OR FURNISHED. SEE ITEM(S) CHECKED:

☐ If the insured was totally disabled to that date, please release this check. If he (she) returned to work before that date, indicate date and return this check. → Date Returned to Work ______

☐ If the insured is still disabled, please have the enclosed form completed and return it to us.

☐

JUL 3 1 1981

POLICY NUMBER	C/D	BR. NO.	NAME OF INSURED
7920	K		Everate Dedeaux

CERT. NO	DIAG CODE	A OR S	STATE	DATE INCURRED	DATE REPORTED	EXAM NO.	DATE COMPUTED	CHECK NO.	DATE CHECKED
8973	99	S	24	5-21-75	3-15-76	916	7-31-81		

CHECK ISSUED PAYABLE TO	AMOUNT PAID
Everate Dedeaux	4921.27
	VALIDATION NO. 508047

G-2856H

Pilot Life
Insurance Company
PO Box 20727
Greensboro, NC 27420
Group Division

Pilot Life

VOID AFTER
6 MONTHS

Check No. A10019663 66-55/531

Patient	Hospital Number	Date Incurred	Date of Check	Acc't. Number	Pay Exactly
		05/21/75	07/31/82	010	$4,921.27

EMP-M

Policy Number
7920 K

Person Insured
DEDEAUX EVERATE

JOHN L KELLY
ENTEX INC
PO BOX 2028
HOUSTON TX 77001

72

To the
North Carolina
National Bank
Greensboro, NC

EVERAT. DEDEAUX

To the
Order of

Pilot Life
Insurance Company

Senior Vice President-Treasurer

G-404E

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

Civil Action No. S80-0467 (R)

EVERATE W. DEDEAUX,
Plaintiff

versus

PILOT LIFE INSURANCE COMPANY,
Defendant

ANSWER TO COUNTERCLAIM

Now comes Everate W. Dedeaux, by and through his undersigned counsel of record, and in answer to the Counterclaim exhibited against him by Pilot Life Insurance Company, answers as follows:

FIRST DEFENSE

The Counterclaim fails to state a claim against the Plaintiff upon which relief may be granted and further fails to state a justiciable claim or controversy for determination under the Federal Declaratory Judgment Act or otherwise.

SECOND DEFENSE

The Counterclaim is barred by the applicable statute of limitations or by the equitable doctrine of laches.

THIRD DEFENSE

And now answering the allegations of the Counterclaim, paragraph by paragraph, Plaintiff says:

1. The allegations of Paragraph I of the Counterclaim, insofar as said allegations attempt to incorporate by reference the Third Defense of the Defendant's Amended Answer, are denied in their entirety. The remaining allegations of Paragraph 1 are admitted insofar as they constitute factual allegations. The allegations concerning the contents of the letter of Mr. David A. Mitchell, which is attached as Exhibit "B" to the Counterclaim, are denied, as said letter speaks for itself.

2. Plaintiff admits that since August 28, 1981, the Defendant has made certain monthly disability payments to him.

3. The allegations of Paragraph 3 of the Counterclaim are denied.

4. The allegations of Paragraph 4 of the Counterclaim are denied. Plaintiff would show that by making the disability payments referred to hereinabove from March 24, 1980, to August 24, 1981, and thereafter, the Defendant waived its right to claim that he was not totally disabled during that period of time and is entitled to no relief by way of declaratory judgment or otherwise.

5. The allegations of Paragraph 5 are denied and the Plaintiff denies that the Defendant is entitled to any relief against him whatsoever.

6. The allegations of the final unnumbered paragraph of the Counterclaim are denied.

FOURTH DEFENSE

Reserving unto himself all of the defenses heretofore asserted and waiving none of them, Plaintiff would affirmatively show unto the Court that his claim for disability benefits was originally denied by the Defendant and that only after the filing of his lawsuit and the commencement of discovery did the Defendant cause to be written the letter which has been attached as Exhibit "B" to its Counterclaim. By this letter, which is in-

corporated herein by reference, the Defendant attempted to rectify or mitigate its prior wrongful conduct by insisting upon paying the disability benefits mentioned in the letter and referred to in Paragraph 1 of the Counterclaim. In doing so, it impliedly admited its wrongful conduct in originally denying the claim and further admitted that the Plaintiff was totally disabled and entitled to benefits within the meaning of the subject policy. In conformity therewith, the check referred to in the Counterclaim was tendered and additional monthly disability benefits were paid to the Plaintiff. By filing the instant Counterclaim, the Defendant seeks to retract this position and allege that the Plaintiff is not now entitled to benefits nor was he entitled to benefits beginning in March of 1980. The Plaintiff would show that by taking the position stated in the letter which is attached as Exhibit "B" and by making the disability payments enumerated in the Counterclaim, the Defendant has waived any right that it had to claim that the Plaintiff was not disabled during the period of time mentioned and is now estopped to assert the position that it has taken in the Counterclaim.

FIFTH DEFENSE

Plaintiff would show that the changing of its position by the Defendant and the filing of the instant Counterclaim constitute compounded acts or gross and incredible misconduct on the part of the Defendant, Pilot Life Insurance Company, which acts further evidence the callous and indifferent attitude that it has displayed toward the Plaintiff, its own insured, out of which this case arises.

AND NOW, having fully answered the allegations of the Counterclaim, Plaintiff denies that the Defendant is entitled to any relief against him whatsoever and demands that the Counterclaim be dismissed, with his proper costs. Plaintiff further re-adopts and re-alleges the allegations of his original Complaint, asserting that

he is entitled to judgment for actual and punitive damages against the Defendant.

Respectfully submitted,

EVERATE W. DEDEAUX

By: DENTON, PERSONS, DORNAN & BILBO

By: /s/ William L. Denton
Of Counsel

CERTIFICATE

I, WILLIAM L. DENTON, attorney of record for the Plaintiff in the above styled and numbered cause, do hereby CERTIFY that I have this day mailed by United States mail, postage prepaid, a true and correct copy of the above and foregoing Answer to Counterclaim to Heidelberg, Woodliff & Franks, 1030 Capital Towers, Jackson, Mississippi 39201, attorneys of record for the Defendant, Pilot Life Insurance Company.

SO CERTIFIED, this 31st day of August, 1982.

/s/ William L. Denton
WILLIAM L. DENTON

DENTON, PERSONS, DORNAN & BILBO
Attorneys at Law
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Biloxi, MS 39533
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P.O. Box 1204
Gulfport, MS 39501
Tel: (601) 864-2418

PETITIONER'S

BRIEF

10

No. 85-1043

IN THE
Supreme Court of the United States
OCTOBER TERM, 1986

PILOT LIFE INSURANCE COMPANY,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF FOR PETITIONER

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September 5, 1986

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52 pp

QUESTIONS PRESENTED

(1) Whether the Employee Retirement Income Security Act ("ERISA") preempts state common law claims of general application, including claims for punitive damages, based upon the alleged improper processing of a claim for benefits under an insured employee benefit plan by an insurance company serving as the plan's claims review fiduciary.

(2) Whether state common law causes of action of general application, sounding in tort and contract, are laws which regulate insurance under Section 514(b) of ERISA and thus saved from preemption.

PARTIES TO THE PROCEEDING

Pilot Life Insurance Company *

Everate W. Dedeaux

---

* Pilot Life Insurance Company is wholly owned by Jefferson-Pilot Corporation. The following are companies that may be deemed affiliates of Pilot Life Insurance Company:

Jefferson Standard Life Insurance Co.
JP Investment Management Co.
Jefferson Pilot Investor Services Inc.
Jefferson Pilot Investment Inc.
Jefferson Pilot Pension Life Insurance Co.
Jefferson Pilot Information Services Inc.
Jefferson Pilot Title Insurance Co.
Jefferson Pilot Fire & Casualty Co.
Jefferson Pilot Property Insurance Co.
Southern Fire & Casualty Co.
JP Growth Fund Inc.
Jefferson Pilot Growth Fund Inc.
JP Income Fund Inc.
Jefferson Pilot Income Fund Inc.
Jefferson Pilot Money Market Fund Inc.
Jefferson Pilot Communications Co.
Jefferson Pilot Communications Co. of Virginia
Jefferson Pilot Publications Inc.

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IN THE

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OCTOBER TERM, 1986

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Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF FOR PETITIONER

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 770 F.2d 1311 (5th Cir. 1985) and appears in the Appendix to the Petition for Certiorari ("Pet. App.") at 1a to 11a. The opinion of the United States District Court for the Southern District of Mississippi granting petitioner's motion for summary judgment is unreported and appears in the Appendix to the Petition for Certiorari at 16a to 18a.

JURISDICTIONAL STATEMENT

The judgment of the Court of Appeals for the Fifth Circuit was entered on September 16, 1985. A timely Petition for a Writ of Certiorari was filed by petitioner

on December 16, 1985, and the petition was granted by Order of this Court dated June 30, 1986. A timely request for an extension of time to file its Brief on the Merits and Joint Appendix was filed by petitioner on July 22, 1986, and an extension was granted by the Clerk up to and including September 6, 1986. The jurisdiction of the Court is invoked pursuant to 28 U.S.C. § 1254(1) (1982).

STATUTES AND REGULATIONS INVOLVED

This case involves Sections 409, 502, 503 and 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1109, 1132, 1133 and 1144 (1982), the McCarran-Ferguson Act, 15 U.S.C. § 1012 (1982), and 29 C.F.R. § 2560.503-1 (1985) promulgated under ERISA Section 503. These provisions are reproduced in the Appendix to the Petition for Certiorari at 35a to 50a.

STATEMENT OF THE CASE

Entex, Inc. ("Entex") sponsors a long-term Disability Plan ("Disability Plan" or "Plan") for employees who become permanently disabled. The Plan is an employee welfare benefit plan governed by ERISA. As plan sponsor and administrator, Entex is responsible for the Disability Plan's day-to-day operation and administration. Benefits under the Plan, however, are provided through a group insurance policy issued by petitioner, Pilot Life Insurance Company ("Pilot Life"). Entex also has delegated Pilot Life responsibility for processing claims for benefits under the Disability Plan.

Respondent, Everate W. Dedeaux, is an employee of Entex, who applied for disability benefits following a back injury in March 1975. Petitioner provided Dedeaux disability benefits under the Plan [1] until March 1980

[1] The Disability Plan provides benefits for up to two years if the employee is prevented from performing the duties of his occupation. Following this initial period, benefits are continued only if the em-

despite a number of disputes over respondent's ability to engage in any gainful employment.[2] In March 1980, Pilot Life terminated Dedeaux's benefits, based upon independent medical reports indicating that he was able to perform light or sedentary work.

Dedeaux did not appeal the termination decision to Pilot Life, pursuant to the Plan's ERISA-mandated internal claims review procedure. Rather, on May 30, 1980, Dedeaux filed suit against Entex and Pilot Life in the United States District Court for the Southern District of Mississippi, based upon diversity of citizenship jurisdiction. His complaint, which included a request for a jury trial, asserted state common law claims for tortious breach of contract, breach of fiduciary duty and fraud. As relief, respondent sought disability benefits in the amount of $463.63 per month, $250,000 in consequential damages for mental distress, and $500,000 in punitive damages. No causes of action were asserted under ERISA.[3]

Following suit, Entex successfully moved for summary judgment on the ground that it had delegated claims processing authority to Pilot Life and thus could not have

ployee is disabled from engaging in "*any and every* occupation or employment for which [he] is reasonably fitted by education, training or experience." (Emphasis added.)

[2] In sharp contrast, the Social Security Administration terminated Dedeaux's social security disability benefits during this period on the ground that he was no longer disabled.

[3] After suit was filed, Pilot Life reinstated Dedeaux's disability benefits retroactively based upon a new independent medical examination. After these benefits were restored, however, Pilot Life received information that Dedeaux had performed numerous activities incompatible with his claim of a disabling back injury, including *inter alia*, carpentry work, shrimping, moving furniture and installing a fence and carpet. Although Pilot Life could have terminated Dedeaux's benefits based upon this new evidence, it instead filed a counterclaim in District Court for judgment and recovery of all disability benefits improperly received.

breached any fiduciary duty owed to Dedeaux. Pilot Life also sought summary judgment asserting that ERISA, and not state law, governed the processing of disability benefits under the Entex Plan. The District Court granted Pilot Life's motion, holding that ERISA preempted respondent's state law claims and provided the "exclusive remedy" for the alleged mishandling of benefits. Pet. App. at 18a.

On appeal, the Fifth Circuit reversed. The Court recognized that ERISA's preemption provision "speaks in sweeping terms," 770 F.2d at 1314, Pet. App. at 4a-5a, and conceded that "Dedeaux would have no claims outside of the ERISA scheme if Entex self-insured the Entex plan." 770 F.2d at 1314, Pet. App. at 6a. Nonetheless, because the Entex Plan was insured by Pilot Life, the Court concluded that Dedeaux's state common law claims were saved by Section 514(b) of ERISA, which exempts all state laws "regulat[ing] insurance" from the broad reach of ERISA preemption.

In so holding, the Fifth Circuit relied principally upon this Court's recent decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985). There, after looking to analogous language in the McCarran-Ferguson Act, this Court interpreted Section 514(b)'s insurance saving clause to encompass a Massachusetts insurance statute which required mental health benefits to be included in all group insurance policies issued in the state, including those purchased by employee benefit plans. The Fifth Circuit read *Metropolitan* to compel the conclusion that Dedeaux's state common law claims were saved from preemption. In the Fifth Circuit's view, these state common law causes of action were indistinguishable from the mandated benefits statute involved in *Metropolitan* in that they both "unquestionably affect[ed] the relationship between the insurer, the insured and the beneficiaries." 770 F.2d at 1316, Pet. App. at 10a. The Court found it irrelevant that the Massachusetts statute

operated in an area left totally unregulated by ERISA, while Dedeaux's state claims arose in an area where ERISA provided specific causes of action. Similarly, the Fifth Circuit rejected petitioner's contention that these state common law claims were incompatible with the federal scheme and would undermine Congress' clear intent to establish uniform standards governing the administration and maintenance of ERISA plans. Rather, it concluded that "state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to, or coequal with any cause of action available under ERISA." 770 F.2d at 1317, Pet. App. at 11a.

The Court reached this conclusion notwithstanding that: (a) neither the plain language of ERISA's saving clause nor the McCarran-Ferguson Act upon which it is based evidences an intent on Congress' part to exempt state common law claims of the type here involved from the broad scope of ERISA preemption; (b) ERISA and its legislative history demonstrate that Congress intended federal standards to be the exclusive source of fiduciary law for all ERISA plans, insured and self-funded plans alike; and (c) the remedies provided by state common law squarely conflict with those provided in ERISA and will have the practical effect of negating the federal remedies.

SUMMARY OF ARGUMENT

At stake in this controversy is the continued supremacy of federal law in the important area of employee benefit plan regulation. Among Congress' principal objectives in drafting ERISA was the elimination of the conflicting system of state and local regulation then governing employee benefit plans. In its place, Congress fashioned a federal regulatory scheme which includes a single standard for evaluating fiduciary conduct and a panoply of enforcement provisions to secure the interests of participants and beneficiaries. To ensure that this pervasive federal framework would be preeminent, Congress de-

vised a sweeping preemption provision of "unparalleled breadth," *Holland v. Burlington Industries*, 772 F.2d 1140, 1147 (4th Cir. 1985), *aff'd mem. sub nom. Brooks v. Burlington Industries*, 106 S.Ct. 3267 (1986), a provision limited only by certain admittedly narrow exceptions.

The lower court ruling now threatens to undermine this statutory scheme by expanding the exceptions to ERISA's preemption provision well beyond the perimeters established by Congress. Acknowledging the breadth of Section 514(a), the Court of Appeals nonetheless ruled that state common law tort and contract actions against insurance companies serving as claims review fiduciaries to employee benefit plans were "saved" from preemption as laws regulating insurance. Because the vast majority of employee benefit plans are underwritten or administered by insurance companies, the decision below will have the inevitable effect of resurrecting state law as the principal mechanism for regulating the administration of employee benefit plans, a result Congress could hardly have envisioned when it crafted the narrow saving clause.

In concluding that state common law actions of general applicability are saved from preemption, the Court of Appeals disregarded a principle firmly rooted in this Court's prior ERISA opinions—that Congressional intent, as reflected in ERISA's text, legislative history and structure, is the key to the Act's proper interpretation. The plain, common sense meaning of the saving clause demonstrates that Congress intended to save from preemption only state law specifically directed at the business of insurance, and not general common law claims which apply to any contract or fiduciary relationship, whether insurance-based or otherwise. Similarly, the lower court misconstrued this Court's command that ERISA be read *in pari materia* with the McCarran-Ferguson Act which generally reserves the business of insurance to the states. Far from encompassing common

law claims of general application, the McCarran-Ferguson Act embraces only statutory or administrative schemes of regulation specifically aimed at the insurance industry.

More importantly, the decision below will totally frustrate Congress' intent, as reflected in ERISA's legislative history, to establish a single set of federal fiduciary principles governing insured and uninsured plans alike. This uniformity of regulation was considered the central feature of Congress' regulatory design and generated widespread support during Congress' consideration of ERISA. Nonetheless, the decision below would subject insurance company fiduciaries to virtually unlimited state regulation in connection with their administration of an employee benefit plan, including the prospect of substantial and unpredictable punitive damages awards. Contrary to the Fifth Circuit's suggestion, such a result does far more than inject some "disuniformity" in Congress' statutory scheme; rather, it displaces that scheme entirely in the insured plan context. Because, in processing claims for benefits, insurance company fiduciaries stand in the place of the plan's trustees and are performing functions that the Fifth Circuit would insulate from state regulation if the plan were uninsured, there can be little doubt that this resurrection of state control is totally at odds with Congress' design.

The decision below also will effectively nullify ERISA's "interlocking, interrelated, and interdependent remedial scheme," *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085, 3093 (1985), for the vast majority of employee benefit plans. ERISA establishes a comprehensive remedial framework for plan participants with benefit claims disputes that is not only detailed and far-reaching, but wholly incompatible with the state tort and contract claims authorized by the Fifth Circuit. Central to that framework is a mandatory internal claims appeal process which offers plan participants and plans alike, a quick, inexpensive and largely informal means

of resolving their differences. Once that internal appeals process is exhausted, plan participants have no right to a jury trial or a de novo review of their claim. Rather, ERISA limits them to a bench trial in which the denial of their claim will be reviewed under an "arbitrary or capricious" standard and, if claims of fiduciary breach are involved, requires them to seek relief in federal court. Even more importantly, as this Court ruled only last Term in *Massachusetts Mutual*, ERISA does not permit a participant to recover punitive or consequential damages for improper processing of benefit claims. The practical effect of the lower court's decision, thus, will be to wholly supplant ERISA's civil enforcement scheme, in direct contravention of Congress' intent to render employee benefit plan regulation a matter of "exclusive federal concern."

Rather than attempting to discern Congress' purpose, the Fifth Circuit ruled that this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), governed resolution of this case. *Metropolitan*, however, involved a state statute regulating the content of group insurance policies, which focused solely on insurance companies and was codified within the state insurance code. In sharp contrast to the common law claims of general application here, that statute clearly constituted a law regulating insurance. Even more fundamentally, that statute addressed an area not regulated by ERISA at all and, thus, invoked none of the preeminent federal regulatory concerns here involved. Finally, contrary to the Fifth Circuit's conclusion, *Metropolitan* acknowledged that *direct* state regulation of employee benefit plans was foreclosed by ERISA. Clearly, state regulation of a plan's processing of a claim for benefits, irrespective of the funding mechanism for the plan, directly intrudes on the administration of the employee benefit plan itself and cannot be sustained.

ARGUMENT

THE DECISION BELOW IS INCOMPATIBLE WITH CONGRESSIONAL INTENT IN ENACTING ERISA AND, UNLESS REVERSED, WILL UNDERMINE THE STATUTORY DESIGN

As this Court has observed, "[i]n deciding whether a federal law pre-empts a state [law], our task is to ascertain Congress' intent in enacting the federal statute at issue." *Shaw v. Delta Air Lines*, 463 U.S. 85, 95 (1983). "The purpose of Congress is the ultimate touchstone." *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978) (quoting *Retail Clerks International Association, Local 1625 v. Schermerhorn*, 375 U.S. 96, 103 (1963)). In interpreting the Congressional purpose underlying ERISA, including enactment of its preemption provision, this Court repeatedly has looked to three factors—the relevant text of the Act, its legislative history, and the structure of the entire statute. *See, e.g., Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085, 3094 (1985); *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380, 2392 (1985); *Shaw v. Delta Air Lines*, 463 U.S. 85, 100 (1983). When these factors are properly considered, there can be little doubt that the lower court misinterpreted Congress' intent in fashioning ERISA's broad preemption provision and created an unprincipled distinction between insured and uninsured plans which threatens the very legislative purposes underlying passage of ERISA.[4]

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[4] Joined by the Department of Labor, the agency charged with administration of ERISA, the Solicitor General has filed an amicus brief urging the Court to overturn the Fifth Circuit ruling. *See* Brief for United States as Amicus Curiae filed May 1986. The grounds advanced therein all support the conclusion that "Congress did not intend to permit participants in insured benefit plans to pursue state common law causes of action of general applicability." Brief for United States at 4. Additional reasons for reversing the lower court opinion may be found in the Brief for Petitioners filed in *General Motors Corp. & Metropolitan Life Insurance Co. v. Taylor*,

I. The Statutory Language of ERISA Does Not Exempt State Common Law Actions of General Application From ERISA's Preemption Clause

A. *The Plain Language of ERISA Section 514 Establishes that Common Law Claims of General Application Are Not Laws Which "Regulate Insurance"*

By its terms, Section 514 broadly preempts "any and all State laws" that "relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1982). This singularly expansive preemption provision, *see, e.g., Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983); *Holland v. Burlington Industries*, 772 F.2d 1140, 1147 (4th Cir. 1985), *aff'd mem. sub nom. Brooks v. Burlington Industries*, 106 S. Ct. 3267 (1986), is qualified by an insurance saving clause which exempts from preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). While the two sections "perhaps are not a model of legislative drafting," *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2389, the starting point for interpreting them remains "the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Id.* (quoting *Park'N Fly, Inc. v. Dollar Park & Fly, Inc.*, 105 S. Ct. 658, 662 (1985)). Giving these provisions their "ordinary," "common sense" meaning, it is clear that state common law actions of general application simply cannot constitute laws "regulating insurance," and, thus, are not saved from preemption.

The state common law causes of action presented by this case—breach of contract, fraud and breach of fiduciary duty—plainly constitute state laws of the broadest general application. These causes of action are equally available in myriad settings and are not directed in any real fashion to the regulation of insurance. Indeed, such actions under Mississippi law are not limited to the insurance context, but have arisen in a variety of different proceedings unrelated to either insurance or the employee benefit area. *See, e.g., Gardner v. Jones*, 464 So. 2d 1144 (Miss. 1985) (fraud in lease agreement); *T.C.L., Inc. v. Lacoste*, 431 So. 2d 918 (Miss. 1983) (breach of contract for cemetery plot); *Tideway Oil Programs, Inc. v. Serio*, 431 So. 2d 454 (Miss. 1983) (breach of fiduciary duty and fraud in oil and gas lease dispute); *M.T. Reed Construction Co. v. Nicholas Acoustics & Specialty Co.*, 387 So. 2d 98 (Miss. 1980) (breach of construction contract); *First American National Bank v. Mitchell*, 359 So. 2d 1376 (Miss. 1978) (fraud and breach of duty of fairness by bank officer); *T.G. Blackwell Chevrolet Co. v. Eshee*, 261 So. 2d 481 (Miss. 1972) (fraud in purchase of automobile); *D.L. Fair Lumber Co. v. Weems*, 16 So. 2d 770 (Miss. 1944) (tortious breach of contract to pasture cattle). These common law actions on their face no more constitute laws regulating insurance than do traffic laws, defamation actions, negligence suits, or other doctrines of general application. Thus, contrary to the Fifth Circuit's ruling, a plain, common-sense analysis of the saving clause leads to the inexorable conclusion that common law actions of general application are not saved from ERISA preemption. *See, e.g., Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 106 S. Ct. 2992 (1986) (saving clause does not exempt state common law claims of general application, but only state laws regulating business of insurance); *Northeast Department ILGWU v. Teamsters Local No. 229*, 764 F.2d 147, 158 n.8 (3d Cir. 1985) (judge-made rules of interpretation of insurance contracts are not the kind of insurance regulation Congress intended to preserve); *Ben-*

Nos. 85-686 & 85-688, a case which has been set for oral argument in tandem with this case. Although the issue in *Taylor*—whether a complaint for employee benefits under an ERISA-covered plan founded on state law may be removed to federal court—presents other potentially dispositive questions, federal preemption of state common law actions of general applicability is an important element of the case.

venuto v. Connecticut General Life Insurance Co., No. 84-3601, slip op. at 16-17 (D.N.J. Feb. 11, 1986) (plain meaning of word "regulate" precludes application of saving clause to contract, fraud and negligence actions).

The construction adopted by the Fifth Circuit not only does violence to the common-sense meaning of the saving clause, but squarely conflicts with the language of the remaining clauses of Section 514. In construing the saving clause to include common law actions of general application not specifically directed at the insurance industry, the Fifth Circuit, for all practical purposes, gave the term "regulate" the same broad meaning as the phrase "relates to" used in Section 514(a).[5] It is a fundamental canon of statutory construction, however, that where Congress used different terms within the same statute, it intended to ascribe a different meaning to each term. *Russello v. United States,* 464 U.S. 16, 23 (1983); *Persinger v. Islamic Republic of Iran*, 729 F.2d 835, 843 (D.C. Cir.), *cert. denied,* 105 S. Ct. 247 (1984). Had Congress intended to draft a saving clause that would embrace all actions of any nature affecting insurance companies, rather than those specifically "regulating" insurance, it presumably would have used the phrase "relates to" in the saving clause. By using the term "regulate" rather than "relate," Congress evidenced an intent to save from the broad reach of preemption only more circumscribed laws specifically focused upon the insurance industry, and *not* general state laws only incidentally affecting insurance.

[5] Noting that the breadth of Section 514(a)'s preemptive reach is apparent from that section's language, this Court has given a broad construction to the phrase "relates to." *See Shaw v. Delta Air Lines*, 463 U.S. 85, 96 (1983). A state law thus "relates to" an employee benefit plan if "it has a connection with or reference to such a plan." *Id.* at 96-97. This expansive definition is precisely the construction which the Fifth Circuit would place upon the term "regulate" in the saving clause. In this manner, a simple common law contract or tort claim could be elevated into a law regulating insurance.

Indeed, in Section 514 itself, Congress clearly recognized the difference between laws of general application and those specifically aimed at a particular economic activity or industry. Thus, in contrast to the narrow focus of the insurance saving clause, Congress specifically saved from preemption "any *generally applicable* criminal law of a State." 29 U.S.C. § 1144(b)(4) (1982) (emphasis added). Had Congress similarly intended to include generally applicable common law actions within the insurance saving clause, it easily could have so provided, as it did in Section 514(b)(4).

B. *Common Law Actions of General Application Similarly Do Not Constitute State Regulation of Insurance Under the McCarran-Ferguson Act, Upon Which ERISA's Saving Clause Is Based*

That common law tort and contract actions are not laws regulating insurance is further supported by the McCarran-Ferguson Act, from which ERISA's saving clause language is drawn. Although the Fifth Circuit peremptorily concluded that the McCarran-Ferguson Act supported the decision below, both the plain language of that statute and its consistent judicial interpretations are to the contrary. Properly construed, neither the McCarran-Ferguson Act, nor, by extrapolation, ERISA itself, is designed to preserve state common law actions of general application from federal preemption.

As this Court observed last Term in *Metropolitan*, ERISA's insurance saving clause "appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Metropolitan Life Insurance Co. v. Massachusetts,* 105 S. Ct. at 2392 n.21. *See also* Manno, *ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action*, 52 Temp. L. Q. 51, 54 (1979). Both statutes "serve the same federal policy and utilize similar

language to define what is left to the states."[6] *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2392 n.21. However, as the Fifth Circuit failed to recognize, the McCarran-Ferguson Act does not preserve state common law actions of general application. First, the state "regulation" of insurance contemplated by Congress in the McCarran-Ferguson Act embraces only *statutory* and *administrative* actions, such as state insurance codes, specifically directed at the insurance industry; it does not encompass judge-made rules such as those preserved by the Fifth Circuit. *See, e.g., SEC v. National Securities, Inc.*, 393 U.S. 453, 459-60 (1969); *Seasongood v. K&K Insurance Agency*, 485 F.2d 729, 734 (8th Cir. 1977); *Crawford v. American Title Insurance Co.*, 518 F.2d 217, 218 (5th Cir. 1975); *Ohio AFL-CIO v. Insurance Rating Board*, 451 F.2d 1178, 1181 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972). Even more significantly, state laws of *general* application—whether statutory, administrative or common law—simply do not constitute state regulation of the business of insurance within the meaning of the McCarran-Ferguson Act. Rather, as the courts have recognized, state laws which generally govern the relationships between private parties are not entitled to McCarran-Ferguson Act protection merely because they apply also to insurance companies. *See, e.g., Hart v. Orion Insurance Co.*, 453 F.2d 1358, 1360 (10th Cir. 1971) (arbitration statutes are "laws of general

[6] The McCarran-Ferguson act provides in pertinent part: "[t]he business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a) (1982). To achieve this purpose, the Act preserves laws enacted by the States for the "purpose of regulating the business of insurance." 15 U.S.C. § 1012(b) (1982). The Act also makes federal antitrust laws applicable to the "business of insurance to the extent that such business is not regulated by state law." *Id.* ERISA's saving clause is similarly worded, exempting from preemption "any law of any State which regulates insurance." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982).

application pertaining to the method of handling contract disputes" and thus are not laws regulating business of insurance); *Hamilton Life Insurance Co. v. Republic National Life Insurance Co.*, 408 F.2d 606, 611 (2d Cir. 1969) (state laws "regulating the method of handling contract disputes generally" not protected by McCarran-Ferguson). Thus, when ERISA's saving clause is read *in pari materia* with the McCarran-Ferguson Act, the common law actions authorized by the Fifth Circuit clearly cannot stand.

This Court's recent decisions also make clear that common law actions of the sort here involved do not implicate the "business of insurance". The Court has looked to three criteria to determine whether a practice constitutes the business of insurance within the meaning of the McCarran-Ferguson Act: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *See Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2391 (quoting *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982)); *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). While respondent's state law claims arguably affect the relationship between the insurer and the insured, they certainly do not effect a transferring or spreading of the policyholder's risk, an element which this Court has described as the "one 'indispensable characteristic of insurance.'" *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 127 (1982) (quoting *Royal Drug*, 440 U.S. at 211-12). Moreover, the common law actions here involved clearly are not specifically limited to entities in the insurance industry, as required by the third factor; they apply generally to all private parties. Thus, contrary to the Fifth Circuit's ruling, an examination of the criteria established by this Court demonstrates that common law

claims of general application are not preserved for state regulation by the McCarran-Ferguson Act. *See* Brief for United States at 17.

The fact that Section 514(c)(1) of ERISA defines state law to include "decisions" as well as "laws," "rules" and "regulations" does not compel a contrary conclusion. First, there is no indication whatsoever that, by including this definition within Section 514, Congress intended to expand the states' power to regulate the business of insurance beyond that traditionally reserved to them by the McCarran-Ferguson Act. To the contrary, the definition of state law was added at Conference and at the same time that ERISA's general preemption provision was *broadened* to embrace "all state laws" relating to employee benefit plans, and not simply state laws dealing with subject matters covered by ERISA. *See* H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 82-83, 383 (1974), *reprinted in* 3 Senate Subcomm. on Labor of the Comm. on Labor and Public Welfare, Legislative History of the Employee Retirement Income Security Act of 1974, at 4277, 4357-58, 4650 (1976) ("Legislative History").[7]

[7] Both House and Senate bills originally provided for preemption of state law related to the subject matters covered by ERISA, *i.e.*, reporting, disclosure and fiduciary responsibilities. *See* S. 3589, 91st Cong., 2d Sess. § 18, 116 Cong. Rec. 7284 (1970); H. 16462, 91st Cong., 2d Sess. § 16, 116 Cong. Rec. 7577 (1970); H.R. 2, 93d Cong., 1st Sess. § 114 (1973), 1 Legislative History 50-51; S. 4, 93d Cong., 1st Sess. § 609(b)(1) (1973), 1 Legislative History 187-88. The Conference Committee rejected these more circumscribed preemption provisions, substituting instead a far broader provision which preempted "any and all State laws insofar as they may . . . relate to any employee benefit plan." H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 82-83, 383 (1974), 3 Legislative History 4357-58, 4650. *See generally Shaw v. Delta Air Lines*, 463 U.S. 85, 98 (1983). Simultaneously, the Committee added Section 514(c)'s broad definition of state law. H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 82-83, 383 (1974), 3 Legislative History 4357-58, 4650. In sharp contrast, the insurance saving clause appeared in its present form in bills introduced in 1970 and remained unchanged throughout the four years of Congressional deliberation. *See* S. 3589, 91st Cong., 2d Sess. § 18, 116 Cong. Rec. 7284 (1970); *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2392 n.23.

Thus, rather than an effort to expand the perimeter of state authority in the insurance field, the definition of state law appears to have been part of Congress' effort to ensure the total "displacement of State action in the field of private employee benefit programs." *See* 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits).[8] Even more importantly, before a state law—whether statutory, administrative or decisional—properly falls within the insurance saving clause, it must still constitute a law "which regulates insurance." State common law claims of general application sounding in contract or tort, which do not primarily or even incidentally relate to insurance, cannot meet this standard.[9]

Even if such claims somehow were deemed laws "regulating insurance", the McCarran-Ferguson Act itself would prevent their application to employee benefit plan

[8] This conclusion is further reinforced by the floor debates surrounding the Conference Committee Report. In commenting on the vastly expanded preemption provision, Representative Dent observed:

> The conferees, with the *narrow* exceptions specifically enumerated, applied [the principle of exclusive Federal control] in its broadest sense to foreclose any non-Federal regulation of employee benefit plans. Thus, the provisions of Section 514 would reach any *rule, regulation, practice or decision* of any State . . . which would affect any employee benefit plan . . . .

120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent) (emphasis added). There is no indication in the legislative history that Congress intended to expand the scope of the saving clause in similar fashion.

[9] Of course, even if the definition of state law fully applies to the saving clause, the "decisional" law to which Congress referred in Section 514(c)(1) need not include state common law actions of general application. "Decisional" law could be a reference to judicial decisions construing or applying state insurance statutes or regulations.

fiduciaries. By its express terms, ERISA does not "alter, amend, modfy, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." ERISA Section 514(d), 29 U.S.C. § 1144(d) (1982). The McCarran-Ferguson Act is a pre-existing law. *See Metropolitan Life Insurance Co. v. Massachusetts*, 105 S.Ct. at 2392 n.21. While the McCarran-Ferguson Act generally permits the states to regulate the business of insurance in such primary areas as licensing, underwriting, reserves and insurance policy content, it also provides that federal legislation which "specifically relates" to the business of insurance will displace any conflicting state law. 15 U.S.C. § 1012(b) (1982).

As the Fifth Circuit recognized, ERISA's fiduciary responsibility and civil enforcement provisions proscribe, and provide relief for, the very actions Dedeaux complains of in this case—the wrongful denial of benefits under an insured employee benefit plan. 770 F.2d at 1316, Pet. App. at 11a. If, as the Fifth Circuit held, state common law claims proscribing and providing relief for this same conduct "affect the 'relationship between the insurer and the insured'" and thus lie at the heart of "'the business of insurance'", *id.*, Pet. App. at 10a, then *a fortiori*, ERISA also "specifically relates" to the business of insurance in this context. Accordingly, ERISA and the McCarran-Ferguson Act would operate in conjunction to preempt Dedeaux's state law claims. As the Ninth Circuit stated in an analogous context:

> Assuming arguendo that [the state law in question] is a state law regulating insurance . . . appellant's argument . . . ignores those ERISA sections that undeniably "specifically relate" to the business of insurance . . . . If McCarran-Ferguson applies, therefore, ERISA falls within the clause excepting federal laws that "specifically relate" to the business of insurance.

Hewlett-Packard Co. v. Barnes, 571 F.2d 502, 505 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

C. *The "Deemer Clause" Precludes Application of State Common Law Causes of Action Arising from Alleged Improper Claims Processing to Insurance Company Claims Administrators*

In any event, the "deemer clause" set forth in ERISA Section 514(b)(2)(B) prohibits the application of state insurance law to an insurance company engaged in performing a mandated ERISA function, such as claims processing, on behalf of a plan. That provision, which was wholly disregarded by the Fifth Circuit, provides that an employee benefit plan shall not be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance." 29 U.S.C. § 1144(b)(2)(B) (1982). This significant qualification on the saving clause reflects, in unmistakable terms, Congress' objective to preclude *direct* state regulation of employee benefit plans themselves, whether by insurance law or otherwise. When a plan delegates administrative responsibilities to a third party, including an insurance company, the deemer clause is fully operative to prevent state interference with that party's plan activities.

That the "deemer clause" prohibits direct state regulation of employee benefit plans was fully recognized by this Court in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985). There the Court determined that the deemer clause was intended to "exemp[t] from the saving clause laws regulating insurance contracts that apply directly to benefit plans." *Id.* at 2390. As a result, the Court concluded that while insured employee benefit plans could be subject to "indirect regulation" focused solely upon an insurance company, such as the mandated benefits statute there at issue, laws that "directly" regulate the insured plan itself were impermissible. *Id.* at 2393.

This prohibition against direct employee benefit plan regulation has been reemphasized in Congressional Reports published after ERISA's enactment. As noted in the 1977 Activity Report of the House Committee on Education and Labor, H.R. Rep. No. 1785, 94th Cong., 2d Sess. (1977), the deemer language was incorporated in ERISA "to create an irrebutable presumption that [employee benefit] plans are not insurance, trust companies, etc., for purposes of state regulation." *Id.* at 47. Moreover, the Report makes clear that regulation addressed to the essential activities surrounding an employee benefit plan necessarily must yield to federal law. Thus, "any activity by a state or political subdivision thereof, which relates to employee benefit plans, qua benefit plans is preempted . . . ." *Id.* at 48.

When the deemer clause is read in conjunction with its underlying purpose, it is clear that state regulation directed to employee benefit plan administration or fiduciary conduct—regulation which strikes at the very core of ERISA—is preempted, even where the plan is administered in part through an insurance company. The processing and review of claims for benefits not only constitute an integral part of employee benefit plan administration, but are directly regulated by ERISA, including ERISA's fiduciary obligation provisions.[10] When an insurance company is delegated responsibility for these plan activities, it is not engaging in the business of insurance. *Cf. Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423-24 (4th Cir. 1985), *cert. denied*, 106 S. Ct. 2892 (1986) Rather, it is acting in the place of the plan's Trustees and is subject to the same exacting fiduciary standards governing their actions. Indeed, by treating insurance companies as "named fiduciaries" and subjecting them to the full range of fed-

[10] *See* ERISA Section 503, 29 U.S.C. § 1133 (1982) and regulations promulgated thereunder, which require plans to establish reasonable internal procedures for handling benefit claims.

eral requirements governing claims processing, both Congress and the Department of Labor have acknowledged that, in this context, insurance companies are proxies for the plan and its Trustees. Accordingly, state regulation of claims processing constitutes the very kind of direct encroachment on a plan's operation that the deemer clause was designed to prohibit.

II. The Decision Below Squarely Conflicts With the Legislative History of ERISA Which Reflects Congress' Intent To Establish Uniform Fiduciary Standards

A "fair contextual reading" of ERISA's insurance saving clause, *see Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. at 3090, demonstrates that Congress did not intend to save state common law actions of general application from preemption. ERISA's legislative history confirms this conclusion. That history not only removes any lingering doubts as to the proper construction of ERISA's preemption provision, but demonstrates that, unless reversed, the Fifth Circuit's decision will eviscerate one of ERISA's principal objectives—the establishment of a single federal regulatory scheme governing fiduciary conduct.

It is abundantly clear that, in enacting ERISA, Congress sought to replace the conflicting system of state and local regulation of employee benefit plans with "a uniform source of law for evaluating . . . fiduciary conduct." Explanatory Statement of the Department of Labor on S. 1557, 119 Cong. Rec. 12075, 12077 (1973). Entrusting fiduciary regulation exclusively to federal control was necessary to eliminate "the need for interstate employers to administer their plans differently in each State in which they have employees." *Shaw v. Delta Air Lines*, 463 U.S. at 105. Recognizing that such multistate regulation had proved unworkable in the past, Congress determined that:

> a fiduciary standard embodied in Federal legislation is considered desirable because it will bring a

> measure of uniformity in an area where decisions under the same set of facts may differ from state to state . . . .
>
> [I]t is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

H.R. Rep. No. 533, 93d Cong., 1st Sess. 12, 2 Legislative History 2359.

To accomplish this goal, Congress established a detailed set of standards and duties to guide fiduciaries.[11] *See* ERISA Section 404, 29 U.S.C. 1104 (1982). Congress also vested the federal courts with *exclusive* jurisdiction over suits alleging a breach of these federal standards.[12] ERISA Section 502(e)(1), 29 U.S.C. § 1132(e)(1) (1982). Finally, and most importantly Congress crafted

[11] ERISA establishes detailed duties of loyalty and care for fiduciaries. Section 404 requires fiduciaries to discharge their duties with respect to a plan "solely in the interests of the participants and beneficiaries" and for the exclusive purpose of providing them benefits. ERISA Section 404(a), 29 U.S.C. § 1104(a) (1982). Further, Section 404 establishes a "prudent person" standard by which to measure the fiduciaries' management, administration and investment of plan assets and other activities undertaken in their employment. 29 U.S.C. § 1104(a)(1)(B) (1982). Similarly, Section 406 prohibits self-dealing and sales or exchanges between the plan and parties in interest. 29 U.S.C. § 1106 (1982). Finally, ERISA Section 405 provides detailed rules governing liability for breaches by a co-fiduciary. 29 U.S.C. § 1105 (1982).

[12] Moreover, ERISA also authorizes the Secretary of Labor to bring an action in federal court to redress a breach of fiduciary duty on behalf of a plan's participants and beneficiaries. ERISA Section 502(a)(2), 29 U.S.C. § 1132(a)(2) (1982), and requires participants to serve a copy of the complaint on the Secretary of Labor, who is granted the right to intervene in such suits. ERISA Section 502(h), 29 U.S.C. § 1132(h) (1982). These provisions similarly highlight Congress' desire to make federal control over fiduciary principles preeminent.

Section 514 as the principal mechanism for implementing its statutory design. From its initial introduction in 1970 until its final passage four years later, ERISA contained an express preemption provision superseding all state laws in the area of fiduciary conduct.[13] *See, e.g.*, S. 3589, 91st Cong., 2d Sess. § 18, 116 Cong. Rec. 7284 (1970); H. 16462, 91st Cong., 2d Sess. § 16, 116 Cong. Rec. 7577 (1970); H.R. 2, 93d Cong., 2d Sess. § 514(a) (1974), 3 Legislative History 4057-58; H.R. 2, 93d Cong., 2d Sess. § 699(a) (1974), 3 Legislative History 3820. This provision—called "the crowning achievement of [the] legislation," 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent)—most clearly reflected Congress' efforts to eliminate the threat of conflicting or inconsistent local regulation and establish in its stead a comprehensive and pervasive federal regulatory scheme. *Alessi*

[13] The legislative intent to preempt all state regulation of fiduciary conduct is well illustrated by H.R. 2, as reported by the House Committee on Education and Labor on October 2, 1973. It included the following preemption clause:

> It is hereby declared to be the express intent of Congress that, if any provision of this Act which relates to an aspect of fiduciary responsibility applies to a plan, then no State law which relates to the same aspect of fiduciary responsibility shall be applied to such plan.

H.R. 2, 93d Cong., 1st Sess. § 514(c)(1) (1973), 2 Legislative History 2346. The Conference Committee ultimately broadened the preemption provision out of fear that the existing version, which superseded only state laws relating to the subject matter of ERISA, would not go far enough in foreclosing the possibility of State regulation. As noted by Senator Javits, the prior version "raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits). To eliminate this possibility, the Conferees settled on a preemption clause which covered not only State laws that fell within ERISA's subject matter, but any law that could directly or indirectly affect employee benefit plans.

v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523 (1981); *see Shaw v. Delta Air Lines*, 463 U.S. at 99.[14]

Nothing in ERISA suggests that Congress drew any distinction between insured and self-funded plans for purposes of the uniform fiduciary standards that it adopted. Indeed, if anything, ERISA indicates that Congress clearly envisioned that its preeminent federal regulatory framework would apply equally to insured plans. Thus, Congress carefully framed the definition of employee benefit plans to include plans established "though the purchase of insurance or otherwise." ERISA Section 3(1), 29 U.S.C. § 1002(1) (1982). Moreover, the statute is replete with references to insurance funding and administration of employee benefit plans, signifying Congress' recognition of the critical role insurance plays in the employee benefit field. *See, e.g.*, ERISA Sections 102(b), 103(a)(2), 401(b)(2), 29 U.S.C. §§ 1022(b), 1023(a)(2), 1101(b)(2); *see also* 29 C.F.R. § 2560.503-1 (1985). ERISA's plain language thus indicates that Congress intended to subject all employee benefit plans, including those funded through or administered by insurance companies, to the same pervasive federal regulation.

ERISA's legislatiive history confirms this view. ERISA, of course, "codifies and makes applicable" to all plan fiduciaries "certain principles developed in the evolution of the law of trusts." H.R. Rep. No. 533, 93d Cong., 1st Sess. 11 (1973), 2 Legislative History 2358. In formulating these federal fiduciary standards, Congress expressed strong concern that insured plans, because of the manner in which they were structured, generally had not been subject to the trust law principles it deemed essential to the adequate protection of the interests of plan participants and beneficiaries. Accordingly, Congress codified these federal "trust" principles, not only to ensure "uniformity", but to ensure that certain "plans, such as *insured plans*, which do not use the trust form as their mode of funding" would be subject to the same exacting standards. *Id.* at 12, Legislative History at 2359 (emphasis added). Thus, far from distinguishing between insured and self-insured plans, ERISA's legislative history makes clear that the Act's fiduciary standards were intended to provide the exclusive source of regulation in both contexts.

The incorporation of the insurance saving clause into Section 514 is not inconsistent with this Congressional objective. Congress fully recognized that under ERISA "state laws regulating banking, insurance and securities [would] remain unimpaired," while simultaneously noting that the Act "provides for a uniform source of law for evaluating the fiduciary conduct of *persons acting on behalf of* employee benefit plans." *See* Explanatory Statement Concerning S. 3589, 116 Cong. Rec. 7286 (1970); Explanatory Statement Concerning H. 16462, 116 Cong. Rec. 7570 (1970) (emphasis added). In contrast to its "repeatedly emphasized purpose" to make federal law preeminent in the fiduciary field, there is a "stark absence" in the legislative history of any intention to save the common law claims preserved by the Fifth Circuit. *See Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. at 3093. Indeed, it is inconceivable that if Congress had intended to exempt insurance company fiduciaries, acting on behalf of employee benefit plans, from the uniform system it established, no reference to this

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[14] The recognition that a single federal framework for fiduciary regulation was of paramount necessity was not confined to the Congress alone, moreover, but was shared by the Administration. Commenting that enactment of legislation containing federal fiduciary standards was "long overdue," Secretary of Labor Schultz acknowledged that ERISA's uniform fiduciary standards would relieve administrators of plans from the "burden of complying with several sets of state laws, rules and regulations," and allow them instead "to formulate procedures and conduct themselves with reference to one uniform law." *See Private Welfare and Pension Plan Legislation: Hearings Before the General Subcomm. on Labor of the House Comm. on Education and Labor*, 91st Cong., 2d Sess. 464, 470 (1970) (testimony of G. Schultz, Sec. of Labor).

fact would have been made in ERISA's legislative history, which spans over 15 volumes of material. Congress' silence on this subject is even more significant inasmuch as over 80% of the welfare benefit plans in the United States are insured and administered by insurance companies.[15] Under these circumstances, Congress simply could not have intended such a dramatic exception to its regulatory scheme without some affirmative indication to that effect. *See NLRB v. Amax Coal Co.*, 453 U.S. 322, 330 (1981).

III. ERISA's Comprehensive Statutory Scheme Precludes a Finding That Congress Intended to Preserve State Common Law Actions of General Application

A. *The Lower Court's Holding Will Void ERISA's Civil Enforcement Provisions*

Besides frustrating Congress' efforts to establish uniform federal fiduciary standards, the Fifth Circuit ruling effectively will nullify ERISA's civil enforcement scheme. As this Court has observed, to assure plan participants and beneficiaries their rights under federal law, Congress provided them with "a panoply of remedial devices" including "six carefully integrated civil enforcement measures." *See Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. at 3093. These measures not only address the very areas of concern embodied in

[15] As the Brief for the United States notes, according to Labor Department statistics, 91% of the welfare benefit plans covering fewer than 100 employees and 83% of welfare benefit plans covering 100 or more employees were insured and administered by insurance companies. 4 Health and Population Study Center, Battelle Human Affairs Research Centers, *Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-1979* at 44 (1980). During this same period, there were an estimated 1.7 million sponsors of private employee welfare benefit plans and over 500,000 private pension plans covering over 50 million participants in the United States. *Id.*, U.S. Depart. of Labor, Labor Management Services Administration, Pension & Welfare Benefits Program, *Estimates of Participants and Financial Characteristics of Private Pension Plans* at 1 (1983).

Dedeaux's state tort and breach of contract claims but provide explicit remedies to correct and deter such putative violations. Thus, under ERISA Section 502(a)(1)(B), respondent could bring a cause of action against Pilot Life to recover benefits due under the terms of the employee benefit plan, to enforce or clarify his rights thereunder or to enjoin Pilot Life from improperly refusing to pay benefits in the future. 29 U.S.C. § 1132(a)(1)(B) (1982). Similarly, respondent could file suit to enjoin Pilot Life from violating either ERISA or the terms of the plan or "to obtain other appropriate equitable relief." ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3) (1982). Finally, to redress any deficiencies in the handling of his claims for benefits, including inordinate delay or lack of good faith, respondent could bring a cause of action against Pilot Life under Sections 409 and 502(a)(2) for breach of fiduciary duty in the administration or management of the plan. 29 U.S.C. §§ 1109, 1132(a)(2) (1982).[16]

That Congress intended this "interlocking, interrelated, and interdependent remedial scheme,"[17] *Massachusetts*

[16] In essence, respondent's state law claims amount to little more than a contract action to recover benefits and breach of the fiduciary obligation to process claims in a fair and reasonable manner. *See, e.g., Allis-Chalmers Corp. v. Lueck*, 105 S. Ct. 1904, 1913-14 (1985). The state tortious breach of contract and fraud claims in the complaint represent in substance only alternative pleading of these same allegations. As noted above, ERISA afforded respondent the same opportunity to recover contractual benefits and redress any fiduciary breaches arising from the handling of his benefit claims.

[17] The remedies afforded by this "comprehensive and reticulated statute" *see Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980), are both detailed and far-reaching. In addition, to those described above, participants and beneficiaries may file suit to enforce the disclosure and reporting provisions of the Act, and, in appropriate cases may be awarded penalties of $100 a day against administrators who fail to comply with a proper request for information. *See* ERISA Sections 502(a)(1)(A), (a)(4), (c), 29 U.S.C. §§ 1132(a)(1)(A), (a)(4), (c) (1982). Similarly, fiduciaries who engage in prohibited transactions under ERISA Section

Mutual Life Insurance Co. v. Russell, 105 S. Ct. at 3093, to be exclusive is apparent not only from the evident care with which it was drafted but from ERISA's legislative history. That history makes clear that ERISA would be "the exclusive form of regulation for employee benefit plans within the areas covered" by the Act, leaving intact only those state laws "which *otherwise* regulate insurance, banking or securities." Explanatory Statement Concerning S. 3589, 116 Cong. Rec. 7284, 7288 (1970) (emphasis added). Further, Congress decreed that *all* actions under ERISA to recover plan benefits, whether brought in federal or state court, would "be regarded as arising under the laws of the United States." H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 327 (1974), 3 Legislative History at 4594. Thus, it was intended "that a body of Federal substantive law [would] be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits). This direction to develop federal common law to govern benefit disputes, as the Brief for the United States observes, presents conclusive evidence that Congress intended to occupy the field of employee benefit plan regulation, to the exclusion of the state remedies authorized by the Fifth Circuit.

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406 may be liable for a civil penalty equal to five percent of the amount involved in the transaction and, if left uncorrected, one hundred percent of that amount. ERISA Section 406, 29 U.S.C. § 1106 (1982); I.R.C. § 4975 (1982). The Act also provides criminal penalties of imprisonment and fines up to $100,000 for willful violations of certain ERISA provisions. *See* ERISA Sections 501, 511, 29 U.S.C. § 1131, 1141 (1982). And if a plan administrator's refusal to pay contractual benefits is both "willful and part of a larger systematic breach of fiduciary obligations," a claimant could seek removal of the fiduciary. *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. at 3093; ERISA Sections 409, 502(a)(2), 29 U.S.C. §§ 1109, 1132(a)(2) (1982). Finally, to ensure that participants and beneficiaries are encouraged to exercise their rights under the Act, ERISA authorizes an award of attorneys fees. *See* ERISA Section 502(g)(1), 29 U.S.C. § 1132(g)(1) (1982).

ERISA's statutory framework, moreover, is plainly incompatible with the state common law claims made available by the lower court. ERISA not only makes fiduciary conduct a matter of exclusive federal concern, it requires *all* suits for fiduciary breach to be brought in federal court; the state courts are expressly denied any authority to hear such claims. ERISA Section 502(e)(1), 29 U.S.C. § 1132(e)(1) (1982). Unlike state contract and tort actions, ERISA does not provide participants a right to a jury trial. *See, e.g., Calamia v. Spivey*, 632 F.2d 1235 (5th Cir. 1980); *Wardle v. Central States Southeast and Southwest Areas Pension Fund*, 627 F.2d 820 (7th Cir. 1980), *cert. denied*, 449 U.S. 1112 (1981); *Chastain v. Delta Air Lines, Inc.*, 496 F. Supp. 979 (N.D. Ga. 1980). Similarly, the standard of review is entirely different. In view of the internal claims review process mandated by the Act, the federal courts do not conduct a hearing *de novo* on a participant's eligibility for benefits; rather, they engage in limited judicial review of the fiduciary's claims review decision to determine whether it was "arbitrary or capricious." *See Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922, 927 (9th Cir. 1986); *Holland v. Burlington Industries*, 772 F.2d 1140, 1148 (4th Cir. 1985), *aff'd mem. sub nom. Brooks v. Burlington Industries*, 106 S. Ct. 3267 (1986); *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182, 187 (3d Cir. 1984); *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454, 457 (6th Cir. 1984), *cert. denied*, 105 S. Ct. 786 (1985). Finally, and most importantly, ERISA, unlike state law, does not permit a participant to recover punitive or consequential damages for improper processing of benefit claims. *See Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085 (1985); *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 424 (4th Cir. 1985), *cert. denied*, 106 S. Ct. 2892 (1986); *Bone v. Association Management Services, Inc.*, 632 F. Supp. 493, 496 (S.D. Miss. 1986).

If left uncorrected, the Court of Appeals' decision will effectively void ERISA's civil enforcement scheme whenever an insured employee benefit plan elects to delegate processing of claims to an insurance company. While participants in self-funded plans will be relegated solely to federal remedies,[18] their counterparts in insured plans will be able to seek relief under ERISA, state common law or both. The prospect of punitive or consequential damages and the less stringent standard of review available under state law will necessarily compel participants in insurance funded or administered plans to eschew their federal rights altogether, and take advantage of the more generous provisions of state common law. Indeed, one need look no further than this case to evidence this fact. As the Court of Appeals observed:

> the reason why Dedeaux did not pursue [his remedies under ERISA] is obvious—Dedeaux sought $500,000 in exemplary damages, but ERISA neither expressly nor implicitly authorizes such an award.

770 F.2d at 1313 n.3, Pet. App. at 3a. Since the vast majority of employee benefit plans are underwritten by insurance, the effect of this decision will be to shift responsibility for policing the private employee benefit plan system to the states. This resurrection of state control simply cannot be squared with Congress' design to establish employee benefit plan regulation as "exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

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[18] The Courts have concluded with virtual unanimity that ERISA Section 514 preempts state common law claims brought against self-insured plans. *See, e.g., Gilbert v. Burlington Industries*, 765 F.2d 320 (2d Cir. 1985), *aff'd mem.*, 106 S. Ct. 3267 (1986); *Authier v. Ginsberg*, 757 F.2d 796 (6th Cir.), *cert. denied*, 106 S. Ct. 208 (1985); *Ogden v. Michigan Bell Telephone Co.*, 571 F. Supp. 520 (E.D. Mich. 1983); *Tolson v. Retirement Committee of Briggs & Stratton Retirement Plan*, 566 F. Supp. 1503 (E.D. Wis. 1983); *Hayden v. Texas-U.S. Chemical Co.*, 557 F. Supp. 382 (E.D. Tex. 1983).

Moreover, the availability of punitive or consequential damages in this context flies in the face of Congress' conscious decision to forego such remedies in ERISA, a decision given due recognition by this Court only last Term in *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085 (1985). In that case, which involved claims against an insurance company administering its own employee benefit plan, the Court held that ERISA Section 409 did not allow participants to recover punitive or consequential damages against fiduciaries, based upon improper processing of a claim for disability benefits. Focusing on ERISA's carefully crafted civil enforcement procedures and its extensive remedial provisions, the Court refused to read into the Act additional remedies not contemplated by Congress. *Id.* at 3093. By authorizing participants to sue insurance company claims fiduciaries for punitive and consequential damages under state common law, the Court of Appeals summarily rendered the *Massachusetts Mutual* decision meaningless for the vast majority of plans covered by ERISA.

Allowing punitive or consequential damages to be awarded against insurance companies serving as claims review fiduciaries will frustrate yet another principle central to ERISA—Congress's desire to minimize the costs necessary to fund the private employee benefit plan system. Throughout its consideration of ERISA, Congress "was acutely aware that under our voluntary pension system the cost of financing pension plans is an important factor in determining whether a pension plan will be adopted." 120 Cong. Rec. 29,953 (1974) (remarks of Sen. Nelson). Congress recognized that if costs were made overly-burdensome, plans would neither be established nor expanded, and an extensive private retirement system would not develop. *Id.* at 29,944-45 (1974) (remarks of Sen. Long). This balancing of costs and protections presumably was among the considerations that

led Congress to foreclose the possibility of punitive or consequential damages awards in ERISA's civil enforcement scheme. *See Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. at 3093 n.17.

If the decision below is allowed to stand, the very economic disincentives Congress hoped to avoid in ERISA could become a reality. By exposing insurance company fiduciaries to substantial and unpredictable damage awards, the costs of funding employee benefit plans will increase significantly. These increased costs will fall not only on the insurance industry and employers, but on the very individuals ERISA was established to benefit—plan participants. Faced with the increased cost of providing insurance coverage to their employees, employers may decide to reduce benefits, or to terminate their health care plans. Employees, on the other hand, may find the health protection that they have come to rely on significantly cut back or denied altogether. This can hardly be what Congress envisioned when it established a federal regulatory scheme to foster "a private insurance system that would operate efficiently, thereby increasing its acceptance and institution among American business." *Taylor v. Bakery & Confectionary Union & Industry International Welfare Fund*, 455 F. Supp. 816, 820 (E.D.N.C. 1978).

B. *The Fifth Circuit's Decision Will Undermine the Claims Review Procedure Established by ERISA*

Beyond negating ERISA's civil enforcement remedies, the lower court's decision threatens the proper administration of employee benefit plans in another significant way—by undermining the internal resolution of benefit disputes contemplated by Congress. Under ERISA Section 503 and regulations promulgated by the Department of Labor, all employee benefit plans, including insurance funded plans, are required to establish a reasonable internal claims procedure which provides for a "full and fair" review of decisions denying benefit claims by an

"appropriate named fiduciary." 29 U.S.C. § 1133 (1982); 29 C.F.R. § 2560.503-1 (1985). The purpose of such procedures is "to reduce frivolous claims, promote the consistent treatment of claims, and create a non-adversarial method of claims settlement." *Taylor v. Bakery & Confectionary Union & Industry International Welfare Fund*, 455 F. Supp. 816, 820 (E.D.N.C. 1978). In particular, Congress desired to afford both plan participants and plans alike, a quick, effective and largely informal means of resolving their differences, without the need to resort to lengthy and expensive litigation. To underscore the importance placed on these objectives, the courts generally have required plan participants and beneficiaries to exhaust the internal claims review procedure established by the plan, prior to filing suit. *See, e.g., Denton v. First National Bank*, 765 F.2d 1295, 1303 (5th Cir. 1985); *Mason v. Continental Group, Inc.*, 763 F.2d 1219, 1227 (11th Cir. 1985), *cert. denied*, 106 S. Ct. 863 (1986); *Kross v. Western Electric Co.*, 701 F.2d 1238, 1244-45 (7th Cir. 1983); *Bonin v. American Airlines, Inc.*, 621 F.2d 635, 639 (5th Cir. 1980); *Amato v. Bernard*, 618 F.2d 559, 567-68 (9th Cir. 1980); *Challenger v. Local Union No. 1, International Bridge, Structural & Ornamental Ironworkers*, 619 F.2d 645, 649 (7th Cir. 1980).

Regulations promulgated by the Secretary of Labor under Section 503 make clear that ERISA's claims review procedure fully applies to plans administered by insurance companies. Those regulations provide that an insurance company, such as Pilot Life, which is charged with review of denied claims, constitutes the "appropriate named fiduciary" for purposes of Section 503. *See* 29 C.F.R. § 2560.503-1(g)(2) (1985); *see also LeFebre v. Westinghouse Electric Corp.*, 747 F.2d 197, 203 (4th Cir. 1984); *Schulist v. Blue Cross*, 553 F. Supp. 248, 252 (N.D. Ill. 1982), *aff'd*, 717 F.2d 1127 (7th Cir. 1983). If participants could resort to litigation despite the proper functioning of these internal appeals procedures,

the benefits of internal review largely would be negated. No benefits dispute could be resolved finally in the internal process since the prospect of litigation over punitive and consequential damages would remain even where a participant received all the benefits to which he was entitled. Even more importantly, participants, like the respondent in this case, could bypass the claims review procedure altogether and instead bring suit in state court in the first instance to resolve benefit disputes. Not only would ERISA's internal review procedure thus be rendered ineffective, but one of the principal goals of internal review—the avoidance of unnecessary litigation—would be defeated.

Faced with similar consequences, this Court has not hesitated to find state common law tort actions preempted by federal law. In *Allis-Chalmers Corp. v. Lueck*, 105 S. Ct. 1904 (1985), the Court ruled that a state tort action brought against an employer and an insurance company administrator for the alleged improper processing of a claim for disability benefits was preempted by Section 301 of the Labor Management Relations Act. There, the participant had bypassed the collectively-bargained grievance procedures, including arbitration. Instead he filed an action in state court for compensatory and punitive damages, alleging intentional breach of the duty of good faith and fair dealing in processing his disability claim. Noting that "[p]erhaps the most harmful aspect of the [lower court] decision is that it would allow essentially the same suit to be brought directly in state court without first exhausting the grievance procedures," 105 S. Ct. at 1915, the Court ruled that the state tort action must give way to federal law. Any other conclusion, the Court found, would "eviscerate a central tenet of federal labor-contract law under § 301 that it is the arbitrator, not the court, who has the responsibility to interpret the labor contract in the first instance." 105 S. Ct. at 1916. In much the same manner,

a central tenet of federal employee benefit law—the required exhaustion of ERISA's internal review procedure—will be eviscerated if the decision below is allowed to stand.

IV. The Fifth Circuit Misconstrued the Court's Decision in *Metropolitan Life Insurance Co. v. Massachusetts* and Erected Unprincipled Distinctions Between Insured and Uninsured Plans Which Congress Did Not Intend

A. Metropolitan *Does Not Reach State Common Law Actions of General Application*

Although the lower court was not "unmindful of the practical consequences of [its] decision" for ERISA's administration, it felt that its interpretation of the insurance saving clause was required by this Court's ruling in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985). Indeed, the Court summarily rejected most of petitioner's arguments—including its contention that Congress intended employee benefit plans to be administered on a uniform, nationwide basis—on the ground that *Metropolitan* made analysis of such considerations unnecessary. In so doing, the lower Court lost sight of the narrow focus of *Metropolitan* and extended that decision far beyond the boundaries erected by this Court.

The admittedly "narrow" question presented in *Metropolitan* was whether a Massachusetts "mandated benefits statute," requiring insurance companies to provide minimum mental health care benefits in group insurance policies written in the state, constituted a law regulating insurance within ERISA's saving clause. The Court found simply that a state statute aimed *directly* at insurance companies, applied *only* to insurance companies and their contracts, and included *within* the state insurance code, constituted such a law. As the Brief for the United States notes, "the words of the saving clause hardly left room for avoiding the conclusion that [the Massachusetts law] was 'a law regulating insurance.'" Brief for United

States at 12. Moreover, the state statute was directed at an area totally unregulated by ERISA—the content of employee benefit plans. *See Shaw v. Delta Air Lines*, 463 U.S. 85, 91-92 (1983). As a result, none of the overriding federal interests present here was implicated.

In sharp contrast, this case involves state common law causes of action which are not directed exclusively or even primarily toward the insurance industry. Rather, they apply generally to *all* contracts or fiduciary relationships. Moreover, these actions not only involve areas expressly regulated by ERISA, but they directly encroach upon the administration of employee benefit plans in disruptive and far-reaching ways. *See* pp. 19 to 21 *supra*. The wholesale displacement of ERISA's standards and remedies and the resulting reemergence of state regulation that is the inevitable result of the lower court's decision easily distinguishes this case from *Metropolitan*.

Not only was the issue presented in *Metropolitan* separate and distinct from that involved here, but the consequences for employee benefit plan administration are far different. The Court's decision in *Metropolitan* recognized only that "national plans" would face some "disuniformities" if they "enter[ed] into local markets to purchase insurance." 105 S. Ct. at 2393. In contrast, the lower court opinion here will generate more than mere "disuniformity" in the employee benefit field—it will frustrate the very principles central to ERISA's statutory scheme. Notwithstanding ERISA's enactment, the vast majority of employees participating in employee benefit plans will be able to pursue widely varying state remedies, which carry with them punitive and consequential damages, and differing procedures, substantial obligations and standards of review. Unlike *Metropolitan*, this dysfunction in the operation of ERISA cannot be viewed simply as an incidental, but "inevitable result" of Congress' desire to save state insurance regulation. Rather, these consequences are directly contrary to Congress' purpose in enacting ERISA.

B. *The Fifth Circuit's Opinion Will Generate Irrational Distinctions Between Insured and Uninsured Plans*

The result reached by the court below not only is unsupported by *Metropolitan*, but, as the Brief for the United States notes, will generate "troublesome and burdensome" distinctions between insured and uninsured plans which Congress could not have intended. Brief for United States at 8. Indeed, these unprincipled distinctions already are evident in the varying results reached by courts interpreting the saving clause. Thus, while insurance companies, like Pilot Life, serving as claims review fiduciaries to *insured* employee benefit plans, have been subject to the full measure of state remedies, insurance administrators of *self-funded* plans generally have been ruled exempt from state common law actions, even though each entity performs exactly the same functions. *See Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922, 926-27 (9th Cir. 1986); *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423-24 (4th Cir. 1985), *cert. denied*, 106 S. Ct. 2892 (1986); *Fisher v. Southwestern Bell Corp. Medical Expense Plan*, No. 86-2068-S, slip op. at 4 (D. Kan. June 26, 1986).[19] Similarly, insurance companies who fund and administer their own plans have received the full measure of ERISA preemption, *see Russell v. Massachusetts Mutual Life In-*

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[19] The demarcation between these two situations is not always clear, moreover. At least one court has ruled that Blue Cross/Blue Shield could be subject to state laws regulating insurance, where it served as a professional administrator to an employee benefit plan. *Insurance Board Under Social Insurance Plan v. Muir*, 628 F. Supp. 1537 (M.D. Pa. 1986). The court found that the plan's contractual arrangement with Blue Cross, under which Blue Cross advanced payment of benefits to participants with a dollar-for-dollar reimbursement from the plan at year end, contained sufficient indicia of "insurance" to bring it within ERISA's saving clause. The court reached this result even though the benefits of the plan in substance were funded entirely from plan assets, and the contract transferred no risk whatsoever to the administrator and thus lacked the essential characteristic of an insurance contract.

surance Co., 722 F.2d 482, 488-89 (9th Cir. 1983), *rev'd on other grounds*, 105 S. Ct. 3085 (1985), even though the very same conduct in the context of insured plans undoubtedly would give rise to state regulation.

The unprincipled line-drawing engaged in by the lower courts is even more troubling where employee benefit plans exhibit both insurance and self-funding characteristics. For example, plans with stop-loss insurance coverage, which provides for insurance funded benefits once certain minimum benefit levels have been exceeded, have met with divergent regulatory results. While the Sixth Circuit would appear to impose state regulation on such plans, *see Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308, 312 (6th Cir. 1985), *cert. denied*, 106 S. Ct. 801 (1986), other courts have characterized such plans as self-funded and thus exempt from state insurance regulation. *See, e.g., Bone v. Association Management Services, Inc.*, 632 F. Supp. 493, 495-96 (S.D. Miss. 1986); *Hutchinson v. Benson Casing Service, Inc.*, 619 F. Supp. 831, 838 (S.D. Miss. 1985); *General Split Corp. v. Mitchell*, 523 F. Supp. 427, 430 (E.D. Wis. 1981). Still others have suggested that such plans will be treated as self-insured so long as the stop-loss coverage is not called into play. *See Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922, 926 (9th Cir. 1986). Carried to their logical conclusion, these cases suggest that participants in the same plan, who have a claim for benefits denied, would have available to them different remedies depending on the size of their claim—those with a relatively modest claim would be relegated solely to their ERISA rights while those with a substantial claim triggering stop-loss limits would be able to avail themselves of state remedies, including punitive damages.

Finally, as this Court has indicated, even *insured* employee benefit plans under appropriate circumstances may escape the impact of the insurance saving clause. As the Court noted in *Allis-Chalmers Corp. v. Lueck*, 105 S. Ct. 1904 (1985), where employee benefit plans are the subject of collective bargaining and incorporate express grievance procedures for benefit disputes, federal, and not state law, will govern such controveries. *Id.* at 1915-16.

These haphazard and illogical results cannot be what Congress intended when it created a national, uniform body of federal substantive law in ERISA. Intervention by this Court, thus, is essential to resolve these conflicting interpretations, to restore federal primacy in this area and to give effect to the Congressional purpose underlying ERISA.

CONCLUSION

The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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September 5, 1986

RESPONDENT'S

BRIEF

(11)

No. 85-1043

IN THE
Supreme Court of the United States
OCTOBER TERM, 1986

PILOT LIFE INSURANCE CO.,
Petitioner,

v.

EVERATE W. DEDEAUX,
Respondent.

On Writ of Certiorari to the United States
Court of Appeals for the Fifth Circuit

BRIEF FOR RESPONDENT

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QUESTION PRESENTED

Whether Section 514(b)(2)(A) of the Employment Retirement Income Security Act (ERISA) saves from preemption, as a law which regulates insurance, the Mississippi common-law action for bad faith refusal by an insurance company to pay insurance benefits due under an insurance policy issued by that company to provide benefits to a beneficiary of an insured plan?

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BRIEF FOR RESPONDENT

STATEMENT OF THE CASE

Pilot Life Insurance Company ("Pilot") issued a group insurance policy to Entex, Inc. ("Entex") to insure a long-term disability benefits plan provided by Entex to its employees. Respondent, an employee of Entex, after injuring his back on March 26, 1975, filed a claim with Pilot for long-term disability benefits. After paying for two years, Pilot refused to pay further disability benefits until employees of both Entex and Pilot urged it to do so. A short time later, however, Pilot again attempted to terminate Respondent's benefits which were reinstated only after Respondent hired an attorney

and after Pilot's in-house legal counsel informed Pilot that, based on Mississippi law, the termination of benefits could not be defended. Pilot, nevertheless, continued its attempts to terminate Respondent's long-term disability benefits and finally did so in 1980 in spite of an independent medical examination confirming continued total disability at the time.

On May 30, 1980, Respondent filed a Complaint demanding, in pertinent part, actual and punitive damages for Pilot's bad faith refusal to pay the long-term disability benefits. (J.A. 20-21). In its answer filed on June 27, 1980, Petitioner admitted the issuance of the group insurance policy, raised certain defenses under the terms of the policy, and attached the Group Insurance Certificate which contained no reference to ERISA. (J.A. 28-30; 32-50). In response to discovery propounded by the Respondent, Petitioner denied that a fiduciary relationship existed between it and Respondent. Almost two years later, Petitioner filed a motion for leave to amend its answer. (J.A. 4). The motion was granted and, on August 6, 1982, the Amended Answer was filed, raising for the first time the ERISA preemption defense: "The Complaint in Count I, Count II and Count III is preempted by 29 USCA § 1001 *et seq.* and specifically by 29 USCA § 1132 and § 1144 which provide for Plaintiff's exclusive remedy in this case." (J.A. 61). Subsequently, on April 19, 1983, Pilot filed a motion for summary judgment, asserting that ERISA preempted Respondent's state law claims. The motion was overruled pursuant to a memorandum opinion signed by the Court on September 29, 1983. Pilot then filed a motion to reconsider this adverse ruling, asserting the same grounds as previously presented. By opinion dated March 19, 1984, the trial court sustained Pilot's motion for reconsideration and granted summary judgment in its favor.

On appeal, the Fifth Circuit reversed the District Court ruling "on the authority of *Metropolitan Life Insurance Co. v. Massachusetts*, —— U.S. ——, 105 S. Ct. 2380, 85 L.Ed.2d 728 (1985), decided after the decision of the District Court." *Dedeaux v. Pilot Life Insurance Co.*, 770 F.2d 1311, 1312 (5th Cir. 1985). The Fifth Circuit noted that the insurer in the *Metropolitan Life* case raised the same arguments Pilot raised in the Fifth Circuit. It concluded that the Supreme Court's unanimous rejection of those arguments clearly and unequivocally repudiated the same arguments Pilot raised on appeal.[1] The Fifth Circuit concluded that the proper analysis of whether a particular law is saved from preemption "ends once it is determined that a law falls within the saving clause and is not exempted by the narrow deemer clause." *Id., citing Metropolitan Life*, 105 S. Ct. at 2993. The Fifth Circuit was, thus, left with the unavoidable conclusion that Respondent's common-law causes of action for Pilot's refusal to pay disability benefits were not preempted.

SUMMARY OF ARGUMENT

Petitioner completely overlooks the clear pronouncement of Congressional intent contained in the ERISA saving clause. Thus, Petitioner argues that other ERISA sections such as those providing for civil remedies or fiduciary duties disclose the intent of Congress. This argument is clearly contrary to Congress' statement that nothing in ERISA, except the deemer clause, shall be construed to limit state regulation of insurance. Since this Court has very recently made clear that the saving clause is to be read as written, it is obvious that a state law which regulates insurance is not preempted.

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[1] Pilot argued that national uniformity would be destroyed, that common-law causes of action could not be laws which regulate insurance, that a distinction between plans that are self-insured and those that are insurance-funded would be indefensible, and that only traditional insurance laws were saved from preemption. *Dedeaux*, 770 F.2d at 1314.

State law includes decisional law according to the United States, this Court, the ERISA definition, and the limited legislative history of the saving clause. Since the Mississippi decisional law of bad faith focuses upon the payment of insurance claims to insureds by insurers, it is clearly a law which regulates insurance. Because the enforcement of insurance claims is at the very core of the business of insurance, the cases decided under the McCarran-Ferguson Act provide additional support for concluding that the Mississippi law of bad faith regulates insurance.

Since the ERISA saving clause expressly prohibits the construction of other ERISA provisions as indicating a Congressional purpose to preempt any state law regulating insurance and since this Court has correctly deferred to Congress for any statutory change, Petitioner's argument that the Fifth Circuit Court of Appeals misapplied this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985) is obviously in error. Since the Circuit Court correctly applied the statute, the decision below should be affirmed.

ARGUMENT

THE FIFTH CIRCUIT COURT OF APPEALS CORRECTLY APPLIED THE ERISA SAVING CLAUSE AS DRAFTED BY CONGRESS AND CONSTRUED BY THIS COURT.

Petitioner's argument [2] is designed to obfuscate the clear and narrow issue of whether the Mississippi common law of bad faith is a law which regulates insurance within the meaning of the ERISA saving clause. Petitioner does so because a focused analysis of that issue in light of the controlling statutory language and this Court's analysis of that language in *Metropolitan Life Insurance Company v. Massachusetts*, 105 S.Ct. 2380 (1985) (hereafter *Metropolitan Life*) can lead to only one conclusion—the Fifth Circuit Court of Appeals reached the correct decision below.

Indeed, unlike Petitioner, the United States admits that the Court of Appeals' decision was based upon conclusions reached by this Court in *Metropolitan Life*. The disagreement with the Circuit Court by the United States results from an erroneous assumption, based upon Petitioner's representations, that the bad faith cause of action recognized by the Mississippi Supreme Court is not focused upon the business of insurance and from an erroneous assumption, expressly contrary to the saving clause itself, as to Congressional intent drawn from the ERISA civil remedies provision. When these arguments and assumptions are tested against the precise language of the saving clause as drafted by Congress and interpreted by this Court in *Metropolitan Life*, it is clear that

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[2] Although the Brief of Amicus is slightly more focused, it is based upon the incorrect assumption, fostered by Petitioner, that the Mississippi common law of bad faith is a law of general application, and it too fails to recognize the controlling effect of the very precise language of the saving clause prohibition against searching for Congress' purpose in other ERISA provisions.

Respondent's state law claim for punitive damages is saved from preemption.

I. THE SAVING CLAUSE PRESERVES STATE LAW WHICH REGULATES INSURANCE.

A. The Saving Clause Controls the Preemption Question.

Although Section 514(a) of ERISA broadly preempts state laws which relate to employee benefit plans, that provision is explicitly limited by the saving clause of Section 514(b)(2). *Metropolitan Life*, 105 S.Ct. at 2389. Thus, Petitioner's focus upon § 514(a) is misplaced.[3] Rather, as directed by this Court, the focus must be upon the language of the saving clause which is to be interpreted according to its ordinary meaning and in light of the presumption against preemption:

> [W]e still have no choice but to 'begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expressed the legislative purpose.' *Park'N Fly, Inc. v. Dollar Park & Fly, Inc.*, 105 S.Ct. 658, 662, 83 L.Ed.2d 582 (1985). We also must presume that Congress did not intend to preempt areas of traditional state regulation. See *Jones v. Rath Packing Co.*, 430 U.S. at 525, 97 S.Ct. at 1309.

Metropolitan Life, 105 S.Ct. at 2389.

The statutory language expressly and broadly states that *nothing* in ERISA *shall be construed* to exempt or relieve any person from any law of any state which regulates insurance, with a *single exception*: "Except as

[3] Respondent has never disputed the broad preemptive effect of Section 514(a) which Petitioner spends so much space in its brief commenting on, quoting the legislative history of, and citing opinions interpreting. (See Brief of Petitioner at pp. 9, 10, 12, 21, 23, 24, 25, 30, 36). The Brief of Amicus also contains many pages dealing with Section 514(a) rather than focusing on the ERISA saving clause. (*See* Brief of Amicus at pp. 7, 8, 9, 10, 11, 12).

provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982). In short, the ERISA saving clause clearly controls[4] the question of preemption of state laws which regulate insurance. Thus, the narrow statutory ERISA question is the same as presented in *Metropolitan Life*: is the questioned law one " 'which regulates insurance' within the meaning of § 514(b)(2)(A), 29 U.S.C. § 1142(b)(2)(A), and so would not be preempted by § 514(a)." 105 S.Ct. at 2389. More specifically, the question posed by the statutory language is whether the Mississippi law of bad faith is "any law of any state which regulates insurance . . . ."

B. The Mississippi Decisional Law of Bad Faith Is a Law Which Regulates Insurance.

(1) *Decisional Law Is Law Which Regulates Insurance.*

Petitioner's argument that only statutory law can be any law of any state is expressly rejected by the United States, is contrary to this Court's pronouncement in *Met-*

[4] The single limitation upon the saving clause is the deemer clause which broadly prevents a plan from being deemed an insurance company. § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1982). Since the deemer clause has no application to a suit against an insurance company which has provided benefits under an insurance contract because such an action does not constitute direct regulation of a benefit plan by deeming the plan, itself, an insurance company, other insurer, or to be engaged in the business of insurance, Petitioner's reliance upon the deemer clause is misplaced. Brief of Petitioner at pp. 19-21. This conclusion is mandated by this Court's analysis of the relationship between the saving and deemer clauses in *Metropolitan Life*: "By exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." 105 S.Ct. at 239.

ropolitan Life, and is contrary to the statute itself as well as its limited legislative history.

The United States has termed unsatisfactory Petitioner's argument that only statutory law is saved:

> [W]e do not think it is satisfactory to distinguish this case ~~from~~ *Metropolitan Life* merely because this case involves decisional law while *Metropolitan Life* involved statutory law.

Brief of the United States at p. 13 n.11.

In reaching this conclusion, the United States relied upon the definition of state law contained in ERISA and on the fact that every appellate court that has addressed the issue has found that ERISA's general preemption provision reaches state common law. *Id.*

The conclusion reached by the United States is consistent with the *Metropolitan Life* decision. In that opinion, this Court did not draw a distinction between the language contained in § 514(b)(2)(A) and § 514(c).[5] Rather, this Court stated that "[t]he insurance saving clause preserves any *state law* 'which regulates insurance, banking, or securities.'" *Metropolitan Life*, 105 S.Ct. at 2389 (emphasis added).

The language used by this Court is consistent with the legislative history. The conference report concerning the saving clause stated, "The preemption provisions of Title I are not to exempt any person from any *state law* that regulates insurance." H.R. Conf. Rep. No. 93-1280, p. 383 (1974) (emphasis added).[6]

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[5] (c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.

29 U.S.C. § 1144(c)(1) (1982).

[6] This Court recognized that the legislative history provides very little discussion of the saving clause and quoted this conference report language. *Metropolitan Life*, 105 S. Ct. at 2392.

The contrived distinction between "any and all State laws" and "any law of any State," drawn by Petitioner and Amicus but rejected by the United States, has been correctly viewed as unjustified.[7] Of course, such a distinction also violates the saving clause prohibition against construing other ERISA provisions as exempting or relieving any person from the law of any state which regulates insurance: "[*N*]*othing* in this subchapter ***shall be construed*** to exempt or relieve any person from any law of any State which regulates insurance . . . ." § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982) (emphasis added).

(2) *The Mississippi Law of Bad Faith Specifically Focuses Upon the Insurance Industry.*

Petitioner admits that the term "regulate" as used in the saving clause means "circumscribed laws specifically focused upon the insurance industry, and *not* general state laws only incidentally affecting insurance." Brief of Petitioner at p. 12. In doing so, Petitioner apparently concedes that if Mississippi bad faith law is focused upon insurance regulation it is saved from preemption.[8] This

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[7] In addition to the authority quoted in the text, it should be noted that one district court has stated, "the meaning of the two phrases is and must be the same. The law of the state is the same as state law." *Lessard v. Metropolitan Life Insurance Company*, 618 F. Supp. 1268, 1270 (D. Me. 1985). See also, *Eversole v. Metropolitan Life Insurance Company, Inc.*, 500 F. Supp. 1162, 1167 (C.D. Cal. 1980).

[8] Petitioner's argument that decisional law may not be saved from preemption has been previously discussed. Petitioner's remaining arguments all revolve around the regulation of insurance question and are hinged upon the incorrect characterization of Mississippi bad faith law as a law of general application which is not focused upon insurance regulation. On almost every page of its brief, no matter what the heading, Petitioner emphasizes the linchpin of its argument with phrases such as "general application," "general applicability," "incidentally affecting insurance." The arguments of Amicus also depend upon the incorrect characterization of Mississippi bad fatih law.

concession was made in the face of the narrow reason for reversing the circuit court offered by the United States and quoted at the outset of Petitioner's argument: " 'Congress did not intend to permit participants in insured benefit plans to pursue state common law causes of action of general applicability.' Brief for United States at 4." Brief of Petitioner at p. 9. As will be made clear below, the reason offered by the United States is faulty because Petitioner mischaracterizes Mississippi bad faith law.

The common law of bad faith as announced and applied in Mississippi clearly is a law of a state which regulates insurance. It is focused upon insurance regulation. It also purports to regulate insurance. Thus, it satisfies the argument of the United States that "regulate" must be given a common-sense meaning. See Brief of United States at pp. 14-15.

Mississippi initially created the independent tort of bad faith for the sole purpose of preventing insurer abuse of insureds:

> If an insurance company could not be subjected to punitive damages it could intentionally and unreasonably refuse payment of a legitimate claim with veritable impunity. To permit an insurer to deny a legitimate claim, and thus force a claimant to litigate with no fear that claimant's maximum recovery could exceed the policy limits plus interest, would enable the insurer to pressure an insured to a point of desperation enabling the insurer to force an inadequate settlement or avoid payment entirely.

Standard Life Insurance Co. of Indiana v. Veal, 354 So. 2d 239, 248 (Miss. 1978).

This focused purpose of insurance regulation because of the lack of other effective state insurance regulation has continued to be the reason the Mississippi Supreme Court has allowed recovery of punitive damages for an

insurer's refusal to pay a legitimate claim for benefits without a legitimate or arguable reason for the claim denial:

> Punitive damages have largely come about in insurance industry cases in this state because of the inferior regulation of our insurance commission of rapacious and deceitful practices by a small minority of the insurance companies doing business in our state. Our insurance industry regulatory laws are singularly incomplete. Furthermore, serious consideration might be given to whether the consuming public has sufficient representation on the commission.
>
> I am confident that virtually all need for punitive damages against insurance companies would quickly dissipate if our state insurance commission were not a toothless tiger or a fox-in-the-chicken-coop situation.

Employers Mutual Casualty Co. v. Thompkins, 490 So. 2d 897, 910 (Miss. 1986) (Justice Hawkins dissenting).

Obviously, the Mississippi Supreme Court views bad faith law as the only law of Mississippi which effectively regulates insurance.

The United States agrees that the common law of bad faith may be viewed as a state law which is focused on the insurance industry and is specifically directed at the insurance industry. Brief of United States at p. 15. Clearly, Mississippi common law, as quoted above, satisfies the United States' test of "a separate and specific tort remedy for bad faith refusal to honor a claim for benefits." *Id.*

Petitioner's argument that the state law claims asserted by Respondent are all laws of general application interestingly fails to cite a single Mississippi bad faith case. Brief of Petitioner at pp. 10-11. Petitioner also fails to denominate Respondent's claim for "Tortious Breach of Contract" (J.A. 18) in its argument and, not surprisingly, fails to refer to the bad faith allegations of Count I, paragraph VII (J.A. 20-21). Rather, Petitioner calls

Respondent's suit one for "breach of contract, fraud and breach of fiduciary duty." Brief of Petitioner at pp. 10-11. Next, Petitioner cites Mississippi cases which recognize the three named causes of action in the non-insurance context, citing only one case purporting to deal with Respondent's bad faith count which case Petitioner erroneously characterizes as "tortious breach of contract to pasture cattle." *Id.* That case actually held that "the breaking down and destruction of another's fence is a tort . . . [which may] justify punitive damages . . . ." *D. L. Fair Lumber Co. v. Weems*, 16 So. 2d 770, 773 (Miss. 1944). In short, Petitioner refuses to address the independent tort of bad faith as created in *Standard Life Insurance Co. of Indiana v. Veal*, 354 So. 2d 239 (Miss. 1978).

Petitioner does admit that the instant case is about punitive damages. Indeed, it is clear that the only reason Petitioner or Amicus argue for ERISA preemption is to avoid punitive sanctions for bad faith refusal to pay legitimate insurance claims. See Brief of Petitioner at pp. 31-32; Brief of Amicus at pp. 22-23. Thus, the real question is not whether the fraud or breach of fiduciary duty [9] claims should be preempted; it is whether the independent tort of bad faith, which was created for the sole purpose of providing punitive sanctions against an insurance company which arbitrarily refused to pay a legitimate claim, is a law which regulates insurance. Since it is such a law because it is focused upon the remedy necessary to compel honest evaluation and payment of insurance claims, the common law of bad faith is saved from preemption.

Even if Mississippi bad faith law were viewed as a law of general application, *Metropolitan Life* makes

[9] Although Petitioner has made much of the fiduciary duty provisions contained in ERISA (Brief of Petitioner at pp. 21-26, 31), in answer to interrogatories and at oral argument in the Fifth Circuit Court of Appeals, Petitioner denied it owed Respondent a fiduciary duty.

clear that, since bad faith directly affects the insurer/insured relationship, it is saved from preemption. Thus, notwithstanding Petitioner's arguments to the contrary, the Fifth Circuit's reliance upon the *Metropolitan Life* decision in rejecting similar arguments below was not misplaced. Indeed, the United States admits that "[t]his Court squarely rejected the argument that ERISA's saving clause was intended merely to preserve from preemption traditional state insurance laws such as those regulating the manner in which insurance may be sold . . . ." Brief of the United States at p. 10. Further, the United States correctly acknowledged that general common law causes of action can be said to regulate insurance. Brief of the United States at p. 15 n.12.[10]

(3) *Insurance Claims Payment Constitutes the Business of Insurance.*

Seizing upon this Court's reliance upon the case law concerning the meaning of the phrase "business of insurance" in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* as additional support for the Court's conclusion that regulation of substantive terms of an insurance contract regulates insurance (*Metropolitan Life*, 105 S.Ct. at 2391), Petitioner argues that regulation of insurance claims payment pursuant to an insurance contract does not regulate insurance. To do so, Petitioner chooses conveniently to ignore this Court's clear holding that enforcement of an insurance contract is the very core of the business of insurance. That holding is based upon

[10] On the authority of *Metropolitan Life*, the United States clearly rejected some additional arguments raised by Petitioner. Thus, the United States recognized that this Court concluded that disuniformities in national plans resulting from the distinction between insured and uninsured plans could not successfully be raised as a reason to construe the saving clause more narrowly. In addition, the United States admitted that this Court rejected the argument that the saving clause authorizes states to regulate only matters not specifically addressed in ERISA. Brief of United States at pp. 10-12.

the historical purpose for passing the McCarran-Ferguson Act and makes obvious that a policyholder's dealing with his insurance company in seeking to receive payment due under the insurance contract constitutes the business of insurance:

> *The McCarran-Ferguson Act was an attempt* to turn back the clock, *to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation.* . . . Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul v. Virginia* held was not "commerce." *The relationship between insurer and insured, the type of policy* which could be issued, *its* reliability, interpretation, and *enforcement—these were the core of the "business of insurance."* Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where *the focus was*—it was *on the relationship between the insurance company and the policyholder.* Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

SEC v. National Securities, Inc., 393 U.S. 453, 460 (1960) (emphasis added).

Petitioner is not aided by its reliance upon the three criteria applied by this Court in cases not so directly involving the policyholder and insurance company relationship. See Brief of Petitioner at p. 15. Certainly, an insurance policy has the effect of transferring or spreading the policyholder's risk, the payment of insurance claims is an integral part of the policy relationship between insurer and insured, and the payment of insurance claims is a practice limited to entities within the insurance industry. *See Metropolitan Life*, 105 S.Ct. at 2391.

The argument that only statutory law is not preempted by ERISA because the McCarran-Ferguson Act prohibits

construing other federal acts as preempting any law enacted by any state is contrary to ERISA, the position taken by the United States, this Court's pronouncement, the legislative history (See Part B.(1), *supra*), and logic. It is an example of Petitioner's use of federal law designed to allow state protection of insureds as a shield against state regulation. The ploy of Petitioner and Amicus is clear—state regulation is to be chosen when federal regulation such as is provided under the anti-trust laws is more effective; federal regulation is to be chosen when state regulation under the decisional law of bad faith is more effective. In the context of ERISA, the insurance industry argues for federal regulation because it will provide less protection for the very persons the statute was designed to provide additional protection. *See*, 29 U.S.C. § 1001 (the policy of ERISA is to protect participants and beneficiaries). In short, neither the policy behind nor the language of the McCarran-Ferguson Act nor ERISA support Petitioner's argument that the business of insurance does not include paying insurance claims.

II. THE SAVING CLAUSE PROHIBITS CONSTRUING OTHER ERISA PROVISIONS AS EVIDENCE OF CONGRESSIONAL INTENT TO PREEMPT STATE LAWS WHICH REGULATE INSURANCE.

This Court has refused to limit the saving clause beyond the limit provided by Congress in the clause itself:

> We therefore decline to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the "deemer clause" which modifies it. If a state law "regulates insurance," as mandated-benefit laws do, it is not preempted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause, whether it be the Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA, or

the insurers' more speculative attempt to read the saving clause out of the statute.

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter. We also are aware that appellants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation.

Metropolitan Life, 105 S.Ct. at 2393.

This refusal is mandated by the saving clause itself:

> Except as provided in subparagraph (B), *nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance* . . . .

§ 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1982) (emphasis added).

In other words, the saving clause expressly states the intent of Congress: other ERISA provisions shall not be construed as reflecting Congressional intent to preempt state laws which regulate insurance.

All the arguments made by Petitioner, Amicus, and the United States which are predicated upon a finding of Congressional intent to preempt Respondent's state law claim because of ERISA provisions other than the saving clause must be rejected. Congress has clearly stated that nothing else in ERISA shall be so construed. Therefore, the arguments that the specific civil remedies provisions [11] and the detailed regulation of fiduciary duties

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[11] The United States admits that this Court's decision in *Metropolitan Life* appears to preclude the arguments made by Petitioner

reveal the intent of Congress (Briefs of Amicus at 18-23, United States at 16, 18-19, and Petitioner at 18, 20, 21-35) are statutorily declared invalid.

In short, Congressional intent is stated in the saving clause itself. That intent is to save from preemption state laws which regulate insurance. Since the Mississippi common law of bad faith regulates insurance, it is saved from preemption. Therefore, the Fifth Circuit Court of Appeals correctly applied the ERISA saving clause to preserve Respondent's state law claim for punitive damages.

CONCLUSION

The decision of the Court of Appeals should be affirmed.

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and the United States that the specific enforcement provisions contained in § 502 override or at least provide insight into congressional intent as to the saving clause:

> As discussed above (pages 11-12, *supra*), *Metropolitan Life* rejected the Massachusetts Supreme Judicial Court's theory that ERISA saved only state regulations unrelated to the substantive provisions of ERISA. The Court's rejection of this approach appears to preclude an argument that respondent's state law claims are preempted solely because ERISA provides procedures for plan participants to enforce their rights.

Brief of United States at p. 18.

REPLY BRIEF

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No. 85-1043

IN THE
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v.
EVERATE W. DEDEAUX,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

REPLY BRIEF FOR PETITIONER

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On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

REPLY BRIEF FOR PETITIONER

As Petitioner's Brief demonstrates, the Fifth Circuit decision, unless reversed, will frustrate Congress' intent to establish a single federal fiduciary standard in ERISA and will effectively nullify ERISA's civil enforcement provisions. Respondent urges the Court to disregard the pervasive evidence of this Congressional intent, and the impact on ERISA of the decision below, arguing that this result is compelled by the Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts,* 105 S.Ct. 2380 (1985). Respondent's Brief not only misinterprets *Metropolitan,* but relies upon a flawed

reading of ERISA that ignores the language, structure and legislative history of the statute. When these factors are considered, there can be no doubt that the state common law actions here involved are preempted by ERISA.

I. COMMON LAW CLAIMS FOR TORTIOUS BREACH OF CONTRACT ARE NOT LAWS THAT REGULATE INSURANCE

Respondent apparently concedes that the fraud and breach of fiduciary duty claims in his complaint are laws of general application and *not* laws regulating insurance. *See* Respondent's Brief at 12. Nonetheless, respondent argues that Count I of the Complaint asserts an "independent tort of bad faith" which constitutes such a law and thus is saved from preemption. This contention both contravenes the plain meaning of the saving clause, and rests on an incorrect analysis of Mississippi law.

What respondent now seeks to characterize as a claim under "Mississippi bad faith law" was labeled a claim for "tortious breach of contract" in his complaint.[1] *See* Petitioner's Complaint, Count I, Joint Appendix at 18. Under Mississippi law, this cause of action permits damages to be recovered for breach of contract "when the breach is attended by such gross negligence or willful wrong as to amount to a tort." *D.L. Fair Lumber Co. v. Weems*, 16 So. 2d 770, 773 (Miss. 1944). This common law action was established by the Mississippi Supreme Court in a line of cases wholly unrelated to either insurance companies or contracts of insurance. *See Hood v. Moffett*, 69 So. 664, 666 (Miss. 1915); *American Railway Express Co. v. Bailey*, 107 So. 761, 763 (Miss. 1926); *D.L. Fair Lumber Co. v. Weems*, 16 So. 2d 770 (Miss. 1944). Moreover, it has *not* been limited to the insurance context, but has arisen in areas totally unrelated to insurance or employee benefit plans. *See, e.g., Fedders Corp. v. Boatright*, 493 So. 2d 301 (Miss. 1986) (breach of warranty contract); *M.T. Reed Construction v. Nicholas Acoustics*, 387 So. 2d 98 (Miss. 1980) (breach of construction contract); *First Money, Inc. v. Frisby*, 369 So. 2d 746 (Miss. 1979) (breach of loan commitment).

[1] Respondent cites Standard Life Insurance Co. of Indiana v. Veal, 354 So.2d 239, 248 (Miss. 1978) as the seminal Mississippi case establishing an "independent tort of bad faith." Yet, as the Mississippi Supreme Court itself has observed, that case nowhere mentions the term "bad faith", *see* Reserve Life Insurance Co. v. McGee, 444 So.2d 803, 807 (Miss. 1983), and concludes only that an intentional refusal to pay a legitimate claim, like any other intentional breach of contract, may give rise to punitive damages. 354 So.2d at 247-48. Moreover, as noted *infra*, claims for tortious breach of insurance contracts rely on the same general common law principles involved in any other contract action.

That this common law cause of action has been applied to insurance companies does not convert it from a law of general application into a law that "regulates" insurance. Claims for tortious breach of contract are based on general common law principles and plainly constitute laws of general application. As the Mississippi Supreme Court has observed, the "assessment is no different in 'bad faith' cases than in other punitive damages cases." *State Farm Fire and Casualty Co. v. Simpson*, 477 So.2d 242, 250 (Miss. 1985). The central inquiry remains whether the alleged tort-feaser acted with such "gross, callous or wanton conduct" or "intentional . . . fraud or deceit" as to warrant recovery of punitive damages. *Id.* As the Fourth Circuit has recently held, such common law actions of general application are not saved from ERISA preemption. *See, e.g., Salomon v. Transamerica Occidental Life Insurance Co.*, 801 F.2d 659, 660-61 (4th Cir. 1986); *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 106 S. Ct. 2892 (1986); *accord Northeast Department ILGWU v. Teamsters Local No. 229*, 764 F.2d 147, 158 n.8 (3d Cir. 1985); *Benvenuto v. Connecticut General Life Insur-*

ance Co., 643 F. Supp. 87, 93 (D.N.J. 1986); *Moulton v. Prudential Insurance Co.*, No. C-85-1829-WWS (N.D. Cal. Jul. 17, 1986).[2]

II. EVEN IF RESPONDENT'S STATE LAW CLAIM IS A LAW REGULATING INSURANCE, IT WOULD STILL BE SUBJECT TO PREEMPTION

Even if respondent's breach of contract claim could properly be considered a law that regulates insurance, the deemer clause in ERISA Section 514(b)(2)(B) would require its preemption in the circumstances of this case. The deemer clause provides that an employee benefit plan shall not be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance." 29 U.S.C. § 1144(b)(2)(B)(1982). As this Court noted in *Metropolitan Life Insurance Co. v. Massachusetts*, that clause was designed to exempt "from the saving clause laws regulating insurance contracts that apply *directly* to benefit plans. . . ." 105 S.Ct. at 2390 (emphasis added). The deemer clause thus expressly precludes *direct* regulation of statutorily required plan functions, like claims processing or discharge of fiduciary obligations, which constitute the very essence of employee benefit plan administration.

There can be no question that respondent's state law claim directly regulates the employee benefit plan in this

[2] The Solicitor General also agrees that such actions are not saved from preemption. "On the merits, while the arguments presented by both sides are not without difficulty, on balance we think Congress did not intend to permit participants in insured benefit plans to pursue state common law causes of action of general applicability." Brief for United States at 4. Moreover, even where a state recognizes a common law action for bad faith refusal to honor a claim for benefits, this action would not be saved as a law regulating insurance. As the amicus brief for the United States notes, it may be that where such actions involve simply "an application of general common law principles, the saving clause should not preserve such a state cause of action." Brief for United States at 15.

case. That claim asserts that Pilot Life breached its duties in its handling of respondent's claim for benefits under the plan. In processing and reviewing claims for benefits, Pilot Life is performing an ERISA-mandated function on behalf of the plan—that of the plan's claims review fiduciary under ERISA Section 503. As the plan's "named fiduciary" for this purpose, it stands in the shoes of the plan's trustees and is subject to the same ERISA responsibilities and obligations that govern their actions. Thus, state regulation of this activity intrudes directly into the administration of the plan itself. Moreover, it does so in areas specifically regulated by ERISA through its fiduciary responsibility (Section 409), claims review procedure (Section 503), and civil enforcement provisions (Section 502). As this Court recognized in *Metropolitan, supra*, this sort of direct intrusion into a plan's operation, particularly in areas of exclusive federal concern, is precisely what Congress sought to prohibit through its enactment of the deemer clause.

Any other construction would effectively eviscerate ERISA's comprehensive civil enforcement remedies which this Court has described as an "interlocking, interrelated, and interdependent remedial scheme," *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S. Ct. 3085, 3093 (1985). Congress fashioned "six carefully-integrated civil enforcement provisions," in ERISA, *id.*, to protect fully the interests of participants and beneficiaries in their employee benefits. Congress further decreed that such remedies would provide "the exclusive form of regulation for employee benefit plans within the areas covered" by the Act. Explanatory Statement Concerning S. 3589, 116 Cong. Rec. 7284, 7288 (1970). Thus, Congress intended that *all* actions for benefits under ERISA, whether brought in federal or state court, would "be regarded as arising under the laws of the United States," H.R. Conf. Rep. No. 1280, 93d Cong., 2d

Sess. 327 (1974), and that ERISA's "panoply of remedial devices," would be invoked, where necessary, to redress all violations of law. *See Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S.Ct. at 3093. To ensure that conflicting or inconsistent state law was entirely displaced by this federal scheme, Congress enacted the "crowning achievement of this legislation"—ERISA's preemption provision. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983).

This "comprehensive and reticulated" statute, with its carefully crafted civil enforcement measures, "provide[s] strong evidence that Congress did *not* intend to authorize other remedies. . . ."[3] *Massachusetts Mutual Life Insurance Co. v. Russell*, 105 S.Ct. at 3093 (emphasis in original). As the Solicitor General and the Department of Labor, the agency charged with enforcement of ERISA, have observed: "We believe there is substantial support in the language and legislative history of ERISA for preserving the exclusivity of ERISA's remedial provisions, even if state law may coexist with federal law in other areas covered by ERISA." Brief for United States at 18. If the state common law claims here involved are available, the civil enforcement provisions contained in ERISA Section 502 no longer would be the

[3] Respondent's suggestion that this Court should not look beyond the deemer clause to determine the scope of ERISA preemption in this case is simply incorrect. At the very least, ERISA's other provisions, statutory structure, and legislative history are relevant in interpreting the deemer clause and determining its limitation on the insurance saving clause. Moreover, plaintiff's myopic approach is refuted by this Court's prior ERISA and preemption opinions, which make clear that a statute's language, structure, and legislative history must be taken into account in determining its preemptive effect. Finally, as demonstrated *infra* and in the Solicitor General's brief, the direct conflict between the state law claims here involved and ERISA's fiduciary responsibility, claims review, and civil enforcement provisions, in and of itself, mandates preemption in this case.

exclusive form of regulation for employee benefit plans. Rather, such remedies would be wholly supplanted by some fifty state laws which, unlike ERISA, may afford punitive and consequential damages and provide vastly differing procedures, obligations and standards of review.[4] Moreover, since over 80% of health benefit plans alone are funded and administered by insurance companies, this wholesale displacement of federal authority by state law would render ERISA obsolete for the vast majority of employee benefit plans. *See* Brief for United States at 19. Such a result would thwart Congress' intent to establish employee benefit plan regulation as "exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

That the deemer clause prohibits direct state regulation of statutorily mandated ERISA functions is further evident in ERISA's fiduciary duty and claims processing sections, provisions that respondent also chooses to ignore entirely. If the decision below is allowed to stand, Congress' efforts to replace conflicting or inconsistent local regulation with "a uniform source of law for evaluating . . . fiduciary conduct," Explanatory Statement of the Department of Labor on S.1557, 119 Cong. Rec. 12075, 12077 (1973), would be frustrated. Rather than

[4] As discussed in Petitioner's Brief, ERISA's basic incompatibility with respondent's state common law claims could not be more clear. The state law remedies here sought not only include punitive damages, but also damages for "anxiety, worry, mental and emotional distress and other incidental damages." Complaint, Joint App. at 21. As the Fifth Circuit observed in this case, "ERISA neither expressly nor implicitly authorizes" exemplary damages, and that was the reason respondent avoided ERISA. 770 F.2d at 1313 n.3, Pet. App. at 3a. Respondent's state law complaint also violates ERISA's command that *all* suits for fiduciary breach be brought in federal court. ERISA Section 502(e)(1), 29 U.S.C. § 1132(e)(1) (1982). And, such claims, as in this case, would be tried to a jury rather than a judge, and an entirely different standard of review would apply.

subjecting insured plans to the same exacting ERISA standards imposed on self-funded plans, as Congress intended, *see* H.R. Rep. No. 533, 93d Cong., 1st Sess 11 (1973), such plans would be subject to widely varying principles of conduct under state law. Moreover, in the context of insurance funded or administered plans, the internal resolution of benefits disputes contemplated by ERISA Section 503 could be avoided at will. Participants, like respondent in this case, could circumvent ERISA's mandated claims review procedure altogether and file suit in state court in the first instance to resolve benefit controversies. This dysfunction in ERISA's operation provides further conclusive evidence that Congress intended that claims of the type here involved should be preempted.

Beyond running afoul of the deemer clause, respondent's state law claims, even if they were laws that "regulate" insurance, would be rendered inoperative by the McCarran-Ferguson Act itself. That act expressly preserves federal regulation which "specifically relates" to the business of insurance. 15 U.S.C. § 1012(b) (1982). ERISA further underscores this preservation of federal authority by providing that it will not "alter, amend, modify, invalidate, impair or supersede any law of the United States." ERISA Section 514(d), 29 U.S.C. § 1144(d) (1982). If, as the Fifth Circuit held, the state common law claims here involved "unquestionably affect the relationship between the insurer, the insured, and the beneficiaries" and thus lie at the "core of the business of insurance," 770 F.2d at 1316, Pet. App. at 10a, then ERISA's fiduciary and civil enforcement provisions similarly "specifically relate" to the business of insurance. Accordingly, ERISA and the McCarran-Ferguson Act would preempt respondent's state law claims in any event. *See Hewlett-Packard Co. v. Barnes*, 571 F.2d 502, 505 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

CONCLUSION

For the reasons stated in the Brief for Petitioner, as well as this Reply, the decision of the Court of Appeals should be reversed.

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January 12, 1987

AMICUS CURIAE

BRIEF

(2)

No. 85-1043

IN THE
Supreme Court of the United States

OCTOBER TERM, 1986

PILOT LIFE INSURANCE CO.,
Petitioner,
v.
EVERATE W. DEDEAUX,
Respondent.

On a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITIONER

The American Council of Life Insurance (the "Council") and the Health Insurance Association of America (the "HIAA") hereby move, pursuant to Rule 36.3 of the Rules of this Court, for leave to file the attached brief as amici curiae. Consent to the filing of this brief has been obtained from counsel for the petitioner. Counsel for the respondent has refused consent.

The Council is the largest life insurance trade association in the United States, representing the interests of 627 member life insurance companies. The Council's

members, which include most of the country's major life insurers, currently hold ninety-five percent of the life insurance in force in legal reserve life insurance companies in the United States. The HIAA represents the interests of 327 member companies. These companies provide over eighty-five percent of the health insurance written by insurance companies in the United States. The combined memberships of the HIAA and the Council represent over ninety percent of the health insurance written by insurance companies in this country.

The insurance industry plays a critical role in providing health and life insurance benefits to members of this nation's workforce through employee welfare benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* Through group policies, insurance companies—including many members of the Council and the HIAA—fund approximately 99 percent of the benefit plans in the United States which cover fewer than 100 participants. *See* "Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-79," Health and Population Study Center, Battelle Human Affairs Research Centers, Vol. IV (1980), at 43-45. Approximately 92 percent of the plans in this country covering greater than 100 participants are funded through insurance. *Id.* In many instances, insurers assume administrative responsibilities for such plans as well. *Id.* Thus, members of the Council and the HIAA make welfare benefit plans possible for countless employers—large and small—thereby ensuring that the great mass of workers in this country receive some form of life and health insurance protection. For example, through group policies issued by insurers, more than 17 million individuals in 1982 were protected by long-term disability insurance programs like the program involved here. *See* HIAA Source Book of Health Insurance Data, 1984 Update, at 9.

Because of their nationwide constituencies, the Council and the HIAA are peculiarly able to present to this Court the views of the life and health insurance industries concerning the issue presented in this case: whether an employee's state common law claims against an insurer for an alleged mishandling of a benefit claim under an insured plan are laws "which regulate insurance" and are thus saved from preemption by Section 514(b) of ERISA, 29 U.S.C. § 1144(b). Those views are particularly important where, as here, resolution of this case requires interpretation of ERISA's "insurance saving clause" and turns in part on the meaning of "regulating the business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1101-12. They are also important because, if the decision below stands, insurers who undertake claims review responsibilities, but not their non-insurer counterparts, will be exposed to suit under widely-varying state common laws—in addition to or in lieu of ERISA—whenever a disgruntled participant challenges the handling of a benefit claim. Because the decision below drastically enlarges the risk of insurers to varying standards of conduct imposed by state common law rules and to substantial, yet unpredictable, compensatory and punitive damages awards, the Council and the HIAA have a direct and substantial interest in this case.

For these reasons, the motion for leave to file the attached brief amici curiae in support of the petitioner should be granted.

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August, 1986

QUESTIONS PRESENTED

(1) Whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts an employee's state common law contract and tort claims, arising from an alleged mishandling of a claim for benefits under an insured employee benefit plan, against an insurance company acting as a claims review administrator?

(2) Whether state common law causes of action of general application, sounding in contract and tort, are laws which regulate insurance under the proper construction of Section 514(b) of ERISA and are thus saved from preemption?

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BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITIONER

INTERESTS OF THE AMICI

As indicated in the Motion accompanying this Brief, the American Council of Life Insurance (the "Council") is the largest life insurance trade association in the United States, representing the interests of 627 member life insurance companies. The Health Insurance Association of America (the "HIAA") represents the interests of 327 member companies. The combined memberships

of the HIAA and the Council represent over ninety percent of the health insurance written by insurance companies in the United States.

The legal and practical consequences of the Fifth Circuit's opinion below are matters of grave concern to the members of the Council and the HIAA. Many members of the Council and the HIAA provide group insurance policies for and administer employee benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA" or the "Act"), 29 U.S.C. §§ 1001 *et seq.* By subjecting insurers that undertake ERISA administrative responsibilities to suit under state common law rules—in addition to or in lieu of ERISA—the decision below drastically enlarges the risk of such insurers to the varying, and often inconsistent, standards of conduct imposed by state common law rules. That risk is heightened by the prospect that the adjudication of benefit claims under diverse state common law rules, rather than ERISA, will be accompanied by substanial, yet unpredictable, compensatory and punitive damages awards. Faced with the uncertainties and inconsistencies fostered by the decision below, members may be unable to provide affordable group insurance policies to employers who sponsor benefit plans, or to undertake administrative responsibilities for such plans. The Council and the HIAA thus have a direct and immediate interest in the issues presented in this case.

STATUTES INVOLVED

This case involves Section 514 of ERISA, 29 U.S.C. § 1144, and the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1012. These provisions are set forth in the Appendix, *infra* pp. 27-28.

STATEMENT

Entex, Inc. ("Entex") sponsors a Long-Term Disability Plan (the "Plan") which provides disability benefits to its employees who become disabled due to work-related injuries. The Plan, which is an employee welfare benefit plan governed by ERISA, pays benefits during the first two years of disability if the employee is unable to perform the duties of his occupation. Thereafter, benefits are payable only if the employee is disabled from "any and every occupation or employment for which [he] is reasonably fitted by education, training or experience." Benefits under the Plan are provided through a group insurance policy issued to Entex by Petitioner Pilot Life Insurance Company ("Pilot Life"). Although Entex is the Plan sponsor and administrator, Pilot Life has responsibility for processing benefits claims under the Plan.

The respondent, an employee of Entex, injured his back in a work-related accident in March, 1975. Respondent sought, and Pilot Life provided, disability benefits for the first two years after respondent's accident. Although disputes arose after the two-year period concerning respondent's continued eligibility for benefits, Pilot Life paid disability benefits to respondent until March, 1980. At that time, Pilot Life discontinued respondent's benefits on the basis of independent medical reports which concluded that respondent was able to perform light or sedentary work.

No internal appeal of Pilot Life's decision to terminate disability benefits, as required by ERISA, was filed by respondent. Rather, on May 30, 1980, respondent brought a diversity action against Entex and Pilot Life in the United States District Court for the Southern District of Mississippi. In his complaint, respondent asserted various state common law causes of action, including breach of contract, breach of fiduciary duty, and fraud. Respondent sought $750,000 in compensatory damages

and $500,000 in punitive damages. Respondent did not assert any claim under ERISA.[1]

The Proceedings Below

On May 21, 1982, Pilot Life moved for summary judgment, asserting, *inter alia*, that ERISA preempted respondent's state law claims relating to Pilot Life's termination of disability benefits. The district court granted the motion, holding that Section 514(a) of ERISA preempted respondent's state law causes of action and that ERISA provided the exclusive remedy for his claims.

On appeal, the Fifth Circuit reversed the decision of the district court. Recognizing the breadth of ERISA's preemption of state law, the court conceded that respondent's claims would have been preempted if Entex had self-insured, rather than purchased insurance for, its Plan. Thus, the narrow issue on appeal was whether Section 514(b)(2)(A) of ERISA—the so-called insurance "saving clause"—released respondent's state tort and contract claims from preemption.

The Fifth Circuit held that it did. Relying principally upon *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), the court below held that ERISA's insurance saving clause, construed in light of analogous language in the McCarran-Ferguson Act, is broad enough to encompass respondent's state common law claims against Pilot Life. Specifically, the court found that these common law claims of general applica-

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[1] As the Fifth Circuit noted on appeal of this action, "[t]he reason why Dedeaux did not pursue this tack is obvious—Dedeaux sought $500,000 in exemplary damages, but ERISA neither expressly nor implicitly authorizes such an award. *Massachusetts Mut. Life Insurance Co. v. Russell*, —— U.S. ——, 105 S. Ct. 3085, 87 L.Ed.2d 96 (1985)." *Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311, 1313 n.3 (5th Cir. 1985) (citations omitted). Mississippi common law, on the other hand, does permit punitive damages awards in certain circumstances. *Id.*

tion, like the mandated-benefit statute at issue in *Metropolitan Life*, are laws "which regulate[] insurance" and, as such, are saved from preemption by Section 514(b) of ERISA. The court thus concluded that "state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to, or coequal with any cause of action available under ERISA." 770 F.2d at 1317.

SUMMARY OF ARGUMENT

By its terms, ERISA preempts "any and all State laws" which "relate to any employee benefit plan." 29 U.S.C. § 1144(a). This is subject to a "saving clause" which exempts from preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144(b). Given the sweeping breadth of ERISA's preemptive reach, the court below concedes—and the parties to this case do not dispute—that state common law rules of general application, when applied to uninsured employee benefit plans, are preempted by ERISA.

Nothing in the words or legislative history of ERISA suggests that the same generally applicable common law rules should survive preemption merely because an employer purchases insurance for, rather than self-insures, an employee benefit plan. In holding that state common law rules of general application are saved from preemption by ERISA's insurance saving clause when applied to insurers acting as claims review administrators, the decision below unravels the preemptive fabric of ERISA and disrupts the uniformity ERISA was designed to promote. It means that state common law rules of general applicability, not specifically directed to insurance, may provide a cause of action in place of or in addition to ERISA whenever an employer purchases insurance for and retains an insurance company to administer its employee benefit plan. Because the great majority of plans are insured or insurer-administered, the decision below

means that state law—more often than ERISA—will determine liability for claims handling under ERISA-governed plans. The decision below thus strikes at the very objectives underlying ERISA: to establish federal primacy over employee benefit plan regulation and to ensure that such plans are uniformly enforced and administered without reference to varying state laws.

Not only does the decision below contravene the intention of Congress to preempt all state laws that fall within ERISA's sphere, but it reaches this result by misconstruing the insurance saving clause contained in Section 514(b) of ERISA. Intended to preserve the McCarran-Ferguson Act's reservation of insurance regulation to the states, the saving clause releases from preemption only those state regulatory schemes which regulate the "business of insurance." It does not shelter state common law rules which apply, in general terms, to the parties to any sort of contract—insurance or otherwise. For this reason, this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), does not require, as the court below concluded, application of ERISA's saving clause here. Unlike the mandated-benefits statute at issue in *Metropolitan Life*, which was focused directly on insurance, the common law rules at issue in this case are not peculiarly applicable to insurers and do not regulate the "business of insurance" within the meaning of either the McCarran-Ferguson Act or ERISA.

Moreover, *Metropolitan Life* does not support the distinction between insured and uninsured plans drawn by the court below. This Court in *Metropolitan Life* recognized that ERISA, by operation of the "deemer clause," distinguishes between insured and uninsured plans when state regulation of the insurance business is involved. But it did not hold—and ERISA does not require—that a similar distinction exists when state common law rules of general application are applied. In holding that insured plans, but not their self-insured counterparts, may be subjected to state common law rules, the court below gave life to a distinction which is unsupported by the words of ERISA, is wholly inconsistent with ERISA's comprehensive remedial scheme, and is entirely unworkable in practice.

ARGUMENT

I. THE DECISION BELOW IS INCONSISTENT WITH THE BROAD PREEMPTIVE LANGUAGE OF ERISA, ITS LEGISLATIVE HISTORY, AND THE POLICIES EMBODIED IN THE ACT

In its simplest terms, this case involves the continued primacy of ERISA in the field of employee benefit plan regulation. The question here is whether ERISA preempts state common law actions against an insurer arising from the alleged mishandling of a benefit claim under an insured employee welfare benefit plan. Relying upon ERISA's narrow insurance saving clause, the court below held that it does not. But the court clearly misapplied the broad command of Section 514(a) of ERISA, as shown by its legislative history, and ignored important policies underlying the Act.

ERISA is a "comprehensive and reticulated statute," *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361-62 (1980), which by its clear terms "supersede[s] any and all State laws insofar as they may now or hereafter *relate to any employee benefit plan. . . .*" 29 U.S.C. § 1144(a) (emphasis added). Evidencing its "unparalleled breadth," *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *aff'd mem.*, 106 S. Ct. 3267 (1986), ERISA preempts not only state statutory enactments relating to benefit plans, but also "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1).

That this "virtually unique pre-emption provision," *Franchise Tax Board v. Construction Laborers Vacation*

Trust, 463 U.S. 1, 24 n.26 (1983), was intended to have a sweeping reach has been recognized by this Court. Indeed, most recently, the Court declined to interpret Section 514(a) so as to limit its preemption to state laws dealing specifically with the subject matters covered by ERISA (e.g., reporting, disclosure, fiduciary responsibility). It concluded instead that ERISA "was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2389. In short, the principles which have emerged from this Court's decisions are clear: that, with several narrowly articulated exceptions, ERISA was intended to make employee benefit plan regulation a matter of virtually exclusive federal concern. *See Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2389; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

This broad view of ERISA's preemption provision is likewise compelled by the Act's legislative history. Throughout its deliberations of ERISA, Congress was acutely aware that establishing a comprehensive federal regulatory scheme was critical to ensuring the uniform administration and enforcement of employee benefit plans. That Section 514 was intended to play a paramount role in achieving uniformity in the application of ERISA—and particularly its fiduciary standards—was emphatically articulated:

> [A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state. . . . [I]t is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973), *reprinted in* 2 Legislative History of the Employee Retirement Income Security Act of 1974 (hereinafter "Legislative History"), at 2359. *See also* 120 Cong. Rec. 29,197 (1974) (remarks of Representative Dent) (broad federal preemption was designed to eliminate "the threat of conflicting and inconsistent State and local regulations"); 120 Cong. Rec. 29,933 (remarks of Senator Williams) ("the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans").[2]

In the development of ERISA, Congress did consider a narrower preemption clause, covering only those aspects of state law relating to the substantive areas covered by ERISA.[3] But as Senator Javits, one of the chief architects of ERISA, explained:

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[2] The Senate Committee similarly stated its intent with clarity:

> Except . . . in certain . . . enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluating fiduciary conduct and for creating a single reporting and disclosure system in lieu of burdensome multiple reports.

S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), *reprinted in* 1 Legislative History, at 621.

[3] *See generally* Hutchinson and Ifshin, "Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974," 46 U. of Chi. L. Rev. 23, 38-43 (1978). Specifically, as passed by the Senate, H.R. 2 provided for preemption of "any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act." H.R. 2, 93d Cong., 2d Sess. § 699(a) (1974), *reprinted in* 3 Leg-

> Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme. . . . [*T*]*he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.*

120 Cong. Rec. 29,942 (1974) (emphasis added). Thus, in choosing the broader preemption clause—called the "crowning achievement of the legislation" [4]—Congress made clear its intent to supersede all state laws that fall within ERISA's substantive reach, and to preempt state laws that more generally apply to employee benefit plans as well.

Nothing in the carefully written exceptions provided in Section 514(a) reflects a contrary intent. Section 514(b)(2) of ERISA—the insurance saving clause—preserves "any law of any State which regulates insurance . . . ," 29 U.S.C. § 1144(b)(2), and was clearly designed to preserve the provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1012. *See Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2392 n.21.[5] Giving those words their common sense meaning, as this Court has done in construing ERISA, *id.* at 2389-90, it is obvious from the words themselves that Congress meant to save

islative History, 3820. This limited language was rejected by the Conference Committee, which chose the more expansive preemption clause. *See* H.R. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. 383 (1974), *reprinted in* 3 Legislative History, 4650.

[4] 120 Cong. Rec. 29,197 (remarks of Representative Dent).

[5] That Act provides in part that "[t]he business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 29 U.S.C. § 1012(a).

from preemption only state legislative and regulatory schemes specifically applicable to insurance—not judicially created laws, or indeed statutory laws, of general application. *See Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 106 S. Ct. 2892 (1986) (the saving clause "exempts from ERISA's preemptive effect only those state insurance laws that regulate the 'business of insurance'" and not state common law claims); *Northeast Dept. ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 158 n.8 (3d Cir. 1985) (court stated in dictum that "judge-made rules regarding interpretation of insurance contracts are not the kind of state insurance regulations that the Congress intended to preserve" in ERISA).[6]

Moreover, the legislative history of ERISA shows that a more sweeping exception to the broad preemption clause contained in the Act was not intended. Rather, the carefully tailored exceptions to Section 514(a) were meant to be construed narrowly. *See, e.g.*, 120 Cong. Rec. 29,197 (1974) (remarks of Representative Dent) ("narrow exceptions specifically enumerated"); 120 Cong. Rec. 29,933 (remarks of Senator Williams) ("narrow exceptions specified in the bill"). Had Congress intended to create an all-encompassing exception for common law rules which, in general terms, relate to the obligations of par-

[6] On the other hand, many courts have concluded—giving the saving clause its intended meaning—that state statutes specifically applicable to the business of insurance are "saved" from preemption by Section 514(b)(2)(A) of ERISA. *See, e.g., Michigan United Food & Commercial Workers Union v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 106 S.Ct. 801 (1986) (state mandated-benefit law); *American Progressive Life and Health Ins. v. Corcoran*, 715 F.2d 784 (2d Cir. 1983) (state insurance law establishing minimum sales commissions); *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (state mandated-benefit law); *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692 (7th Cir. 1977) (state insurance law forbidding sale of unauthorized group policies).

ties to *any* contract—insurance or otherwise—it surely could have done so. Congress obviously knew how to exempt laws of general application in ERISA, as it did when it saved from preemption "any *generally applicable* criminal law of a State." 29 U.S.C. § 1144(b)(4) (emphasis added).

Against this background, the collision of the decision below with the legislative intent underlying the Act is quite clear. In holding that state common law actions arising from alleged mishandling of benefit claims are not preempted by ERISA when asserted against insurers acting as claims review administrators, the decision below ignores the clear intent of Congress to "establish[] benefit plan regulation 'as exclusively a federal concern,' *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S., at 523, . . . [and to] minimize[] the need for interstate employers to administer their plans differently in each State in which they have employees." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 105. Because it permits the practices of the states, as reflected in their common law rules, to assume a prominence equal, if not superior, to ERISA with respect to the handling of benefit claims, the decision below achieves precisely the result Congress carefully sought to avoid when it enacted ERISA.

II. THE FIFTH CIRCUIT'S APPLICATION OF ERISA'S SAVING CLAUSE IS INCONSISTENT WITH THIS COURT'S CONSTRUCTION OF AND CONGRESSIONAL INTENT UNDERLYING THE MCCARRAN-FERGUSON ACT

Not only does the decision below contravene Congress' explicit intent to give ERISA a sweeping preemptive reach, but the decision rests upon a fundamental misinterpretation of the language of ERISA's saving clause. In holding that a state common law rule of general application is a law "which regulates insurance" within the meaning of Section 514(b), the court below gave the saving clause an unduly broad reading. Properly construed,

the saving clause can only apply to state regulatory schemes specifically applicable to insurance, like those protected by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1012, and not to judicially-created laws of general application in all fields.

The McCarran-Ferguson Act provides in relevant part that "[t]he business of insurance . . . shall be subject to the *laws of the several States which relate to the regulation or taxation of such business*." 15 U.S.C. § 1012(a) (emphasis added). "The blanket grant of authority to the states in the insurance area is, however, no more all-encompassing than the blanket interdiction against them in the employee benefit field." Manno, "ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action," 52 Temp. L. Q. 51, 54 (1979). That interdiction, found in Section 514 of ERISA, mandates preemption of all state laws which directly or indirectly "relate to" employee benefit plans. But "to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States," *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2392 n.21, ERISA saves from preemption "*any law of any State which regulates insurance*." 29 U.S.C. § 1144(b)(2)(A) (emphasis added).[7]

The conclusion that ERISA's saving clause is properly limited to state statutory schemes regulating insurance is supported, if not compelled, by the construction given to the strikingly similar words used in the McCarran-Fer-

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[7] Congress' extraction of words from the McCarran-Ferguson Act for use in ERISA was clearly not accidental. In addition to the language quoted above, the "deemer clause" set forth in Section 514(b) of ERISA provides that "an employee benefit plan . . . shall [not] be deemed to be an insurance company or other insurer . . . or to be engaged in the *business of insurance* . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts. . . ." 29 U.S.C. § 1144(b)(2)(B) (emphasis added).

guson Act to establish state primacy over insurance regulation. *See Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. at 2391. While a unanimous approach to the meaning or scope of the saving clause has not emerged in the decade of ERISA's existence, a rather uniform interpretation has been provided by courts to analogous language in the McCarran-Ferguson Act. Dealing with the meaning of "regulating the business of insurance," this Court in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), provided support for the argument that "regulation" of insurance encompasses legislative and administrative actions directed to the insurance business, and not actions brought under generally applicable state common law. In that case, the Court stated:

> Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the [McCarran-Ferguson Act] apply. Certainly the fixing of rates is part of this business. . . . The selling and advertising of policies, *FTC v. National Casualty Co.*, 357 U.S. 560 (1958), and the licensing of companies and their agents, *cf. Robertson v. California*, 328 U.S. 440 (1956), are also within the scope of the statute. Congress was concerned with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement —these were the core of the 'business of insurance.' . . . But whatever the exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. *Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'*

Id. at 459-60 (emphasis added). *See also FTC v. National Casualty Co.*, 357 U.S. 560, 564-65 (1958) (*per curiam*) (in concluding that states had "regulated" insurance by enacting prohibitory legislation authorizing

administrative enforcement, the Court declined to decide whether there was any distinction in the McCarran-Ferguson Act between "legislation" and "regulation").

That the "business of insurance" was not meant to include generally applicable state common law rules which only incidentally relate to insurance is further supported by this Court's more recent decisions. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, *reh'g denied*, 441 U.S. 917 (1979).[8] In *Pireno* and *Royal Drug*, this Court articulated three criteria for determining whether a particular activity constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. at 129. An even cursory examination of these criteria reveals that state common law rules relating generally to damages for failure to meet contract obligations cannot be deemed the regulation of insurance. They certainly do not purport to affect spreading or transfering the policyholder's risk, which is the "one 'indispensable characteristic of insurance'." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. at 127 (*quoting Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 211-12). Nor are they specifically limited to entities in the insur-

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[8] The distinction between laws of general application and laws regulating insurance has also been drawn by some lower federal courts in interpreting the McCarran-Ferguson Act. *See, e.g., Hart v. Orion Ins. Co.*, 453 F.2d 1358, 1360 (10th Cir. 1971) (arbitration statutes are "laws of general application pertaining to the method of handling contract disputes," and thus do not regulate the business of insurance within the McCarran-Ferguson Act); *Hamilton Life Ins. Co. v. Republic National Life Ins. Co.*, 408 F.2d 606, 611 (2d Cir. 1969) (same).

ance industry or an "integral" part of the insurer-insured relationship. Rather, they are generally applicable to parties to any type of contractual relationship—insurance or otherwise—and, accordingly, are not laws "which regulate[] insurance," as the court below found. *See Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 106 S. Ct. 2892 (1986); *Benvenuto v. Connecticut General Life Insurance Co.*, No. 84-3601 (D.N.J. Feb. 27, 1986).[9]

Nothing in the legislative history of the McCarran-Ferguson Act supports a contrary result. Indeed, in discussing the proviso to Section 2(b) dealing with federal antitrust laws, Senator Ferguson shed light on the meaning of "regulation" in that Act:

> Mr. O'Mahoney. I believe the Senator from Michigan went a little further than was his intention when he said that if the States have *legislated* certain things will take place. The bill says if the States have *regulated*.
>
> Mr. Ferguson. I had reference to *legislation dealing with regulation and taxes*.

91 Cong. Rec. 1443 (1945) (emphasis added). The great care exercised by Congress in discussing the meaning of this critical term is evident from other passages of the

[9] Congress surely understood the distinction between insurance regulation and common law rules of general application when it enacted ERISA. Indeed, in the definitional section found in Section 514, Congress expressly defined "State law"—a phrase it did *not* use in the insurance saving clause—as "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1). Congress' use of the phrase "State law" in Section 514(a), but not in Section 514(b)(2)(A), was almost surely intentional. It is entirely consistent with the terms and policies of the Act for Congress to preempt all "State law" relating to benefit plans, including decisional and administrative laws, while saving from preemption only state regulatory laws applicable to the business of insurance within the meaning of the McCarran-Ferguson Act.

legislative history, as for example, where Senator McCarran, the other chief sponsor of the bill, stated:

> . . . the States may, if they see fit to do so, *enact legislation for the purpose of regulation*. If they do *enact such legislation*, to the extent that they *regulate* they will have taken the business of insurance in the respective States out from under the Sherman Anti-trust Act, the Clayton Act and the other acts.

91 Cong. Rec. 1443 (1945) (emphasis added).[10] Thus, in its deliberations on the McCarran-Ferguson Act, Congress made clear its intent that regulation meant the exercise of control by regulatory agencies over insurance, pursuant to state legislation.

Reading the language of the McCarran-Ferguson Act in *pari materia* with ERISA's saving clause thus reveals the infirmities inherent in the analysis of the court below. The decision below—that a state common law rule of general applicability is a law "which regulates insurance" within the meaning of ERISA when applied to an insurer's handling of benefit claims—purports to draw its strength from an analogous statute which, in no uncertain terms, supports a contrary result. To permit that decision to stand would be to upset a delicate balance struck by Congress when it enacted ERISA—a balance which established federal primacy in the field of employee benefits while it narrowly saved traditional state authority, as preserved in the McCarran-Ferguson Act, to regulate the business of insurance.

[10] Other similar examples of Congress' intent concerning the meaning of "regulation" abound. *See, e.g.*, 91 Cong. Rec. 1444 (1945) (remarks of Senators McCarran and White); 91 Cong. Rec. 481-82 (remarks of Senator Radcliffe); 91 Cong. Rec. 1087 (remarks of Representative Hancock); 90 Cong. Rec. 6525 (1944) (remarks of Representative Hancock). *See also* Weller, "To Preempt or to Accommodate: The Question of State and Federal Antitrust Laws under the McCarran-Ferguson Act," 9 U. Tol. L. Rev. 421 (1978).

III. THE DECISION BELOW MISAPPLIES THIS COURT'S DECISION IN *METROPOLITAN LIFE INSURANCE CO. v. MASSACHUSETTS* AND DRAWS AN UNWORKABLE DISTINCTION BETWEEN INSURED AND UNINSURED PLANS

In holding that state common law claims for breach of contract, breach of fiduciary duty, and fraud are not preempted by ERISA, the court below relied upon this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985). Nothing in *Metropolitan Life*, however, compels a finding that state common law rules of general application, as opposed to laws which specifically "regulate" insurance, are saved from preemption by ERISA's insurance saving clause.

A. *Metropolitan Life* Does Not Require Exemption of State Common Law Actions from ERISA's Preemptive Reach

The narrow issue presented to this Court in *Metropolitan Life* was whether Massachusetts' mandated-benefit law, which required insurers to provide for certain mental health care benefits in insurance policies issued to Massachusetts residents, was a law which "regulates insurance" within the meaning of ERISA's saving clause. Reaffirming its conclusion that ERISA's preemptive scope is broad, the Court stated that all state laws which "relate to" employee benefit plans, like the mandated-benefit law at issue, are preempted unless saved by Section 514(b). In addressing the application of ERISA's saving clause, the Court relied upon the "common-sense view" of the Act's language and upon analogous language in the McCarran-Ferguson Act. Finding that the McCarran-Ferguson Act "strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws 'which regulate insurance,'" *id.* at 2391, the Court concluded that the mandated-benefit law at issue was saved from preemption.

The court below misconstrued this Court's decision in *Metropolitan Life* when it held that state common law claims for breach of contract, breach of fiduciary duty and fraud were saved from preemption by Section 514(b) of ERISA. This Court's decision in *Metropolitan Life* involved the application of ERISA's saving clause to a state mandated-benefit statute applying *only* to insurance and insurers, which clearly constituted a regulation of insurance. Unlike state statutes regulating the content of insurance contracts, however, the present case involves state common law rules *generally applicable* to the relations of parties to any sort of contract. Such common law rules do not regulate the substantive content of insurance contracts; nor are they peculiarly applicable to the insurer-insured relationship. Thus, contrary to the conclusion of the court below, *Metropolitan Life* does not sweep so broadly as to prevent the application of ERISA's expansive preemption clause to the state common law actions at issue here.

B. *Metropolitan Life* Does Not Support the Distinction Between Insured and Uninsured Plans Drawn by the Court Below

Nor does *Metropolitan Life* require, as the court below suggests, an unnatural enlargement of the distinction between insured and self-insured plans created by Section 514(b)(2)(B) of ERISA. The so-called "deemer clause", which qualifies the insurance saving clause, provides that no employee benefit plan shall be "deemed" to be an insurance company or engaged in the business of insurance for purposes of any law of any state which regulates insurance. 29 U.S.C. § 1144(b)(2)(B). But the distinction created by the deemer clause is relevant only when states regulate the business of insurance. It provides no basis for preventing the preemption of state common law rules of general applicability as applied to either insured or uninsured plans.

This Court in *Metropolitan Life* "gave life to a distinction created by Congress in the 'deemer clause'", 105 S.

Ct. at 2393, when it held that insured plans, but not uninsured plans, are governed by state *statutes* regulating the content of insurance contracts. That decision did not, however, state or suggest that a similar distinction applies when state common law claims, like those at issue here, are involved.[11] Nor would so facile a distinction—a distinction rendering insured plans, but not their uninsured counterparts, subject to the varying standards and remedies available under state common laws—be supportable under ERISA. Indeed, ERISA's fiduciary standards apply to all "employee welfare benefit plans"—*regardless* of whether they are funded *"through the purchase of insurance or otherwise."* 29 U.S.C. § 1002(1). Surely, Congress did not intend to apply uniform federal standards to fiduciaries of self-insured plans, and, at the same time, require insurer-administrators to assess the legality of their conduct under entirely different—and widely varying—state laws.

Moreover, the expanded distinction drawn by the court below is entirely unworkable in practice, as the divergent results achieved by the lower federal courts addressing ERISA's preemptive reach clearly show. Not surprisingly, many courts have held that ERISA preempts state common law actions arising from mishandling of benefit

[11] By declining to read a broader distinction into ERISA, this Court would not render the "deemer clause" meaningless. Indeed, adhering to this Court's decision in *Metropolitan Life,* several courts have held that state insurance *statutes,* by operation of the deemer clause, do *not* apply to self-funded employee benefit plans. *See, e.g., Children's Hospital v. Whitcomb,* 778 F.2d 239 (5th Cir. 1985) (Louisiana's mandated-benefits statute held inapplicable to self-insured plans); *Dillard v. Teamsters Council 83 Health & Welfare Fund,* 6 Emp. Ben. Cas. (BNA) 2558 (W.D.Va. 1985) (state anti-subrogation statute preempted when applied to self-funded plan); *Cuttle v. Federal Employees Metal Trades Council,* 623 F. Supp. 1154 (D. Me. 1185) (state insurance conversion statutes preempted by ERISA to the extent that they apply to self-insured plans); *Kilmer v. Central Counties Bank,* 623 F. Supp. 994 (W.D. Pa. 1985) (state no-fault insurance statute held inapplicable to self-funded plan).

claims, including claims for breach of fiduciary duty, breach of contract and fraud. *See, e.g., Light v. Blue Cross and Blue Shield of Alabama,* 790 F.2d 1247 (5th Cir. 1986), *aff'g,* 616 F. Supp. 558 (S.D. Miss. 1985); *Blakeman v. Mead Containers,* 779 F.2d 1146 (6th Cir. 1985); *Ellenburg v. Brockway, Inc.,* 763 F.2d 1091 (9th Cir. 1985); *Hutchinson v. Benton Casing Service, Inc.,* 619 F. Supp. 831 (S.D. Miss. 1985); *Lucash v. Strick Corp.,* 602 F. Supp. 430 (E.D. Pa. 1984), *aff'd mem.,* 760 F.2d 259 (3d Cir. 1985). Like the court below, however, a number of courts—with some notable exceptions [12] —have concluded that the *same* common law actions, when applied to insurer-administrators are not preempted. *See, e.g., Trogner v. New York Life Insurance Co.,* 633 F.Supp. 503 (D. Md. 1986); *Kanne v. Connecticut General Life Insurance Co.,* 607 F. Supp. 899 (C.D. Cal. 1985); *Lessard v. Metropolitan Life Insurance Co.,* 618 F. Supp. 1268 (D. Me. 1985); *McLaughlin v. Connecticut General Life Insurance Co.,* 565 F. Supp. 434 (N.D. Cal. 1983);

[12] In *Powell v. Chesapeake & Potomac Telephone Co.,* 780 F.2d 419 (4th Cir. 1985), *cert. denied,* 106 S. Ct. 2892 (1986), an employee sued her employer and the insurer-administrator of a self-funded employee welfare benefit plan for mishandling her claim for disability benefits. The plaintiff alleged, *inter alia,* breach of contract, breach of the implied covenant of good faith and fair dealing, and intentional infliction of emotional distress, and sought $5 million in extracontractual and punitive damages. The Court of Appeals for the Fourth Circuit held that ERISA preempted plaintiff's state common law claims relating to the plan, and rejected her argument that such claims, when asserted against an insurer, are preserved by ERISA's insurance saving clause. Finding that such claims do not regulate the business of insurance within the McCarran-Ferguson Act or ERISA, the court held that plaintiff's common law claims were not saved from preemption. *See also Moore v. Provident Life & Accident Insurance Co.,* 786 F.2d 922 (9th Cir. 1986) (saving clause does not preserve common law actions against insurer that provides excess insurance for self-funded plan and reviews administrator's claims decisions); *Benvenuto v. Connecticut General Life Insurance Co.,* No. 84-3601 (D.N.J. Feb. 27, 1986) (saving clause does not preserve state common law claims against insurer-administrator of insured plan).

Presti v. Connecticut General Life Insurance Co., 605 F. Supp. 163 (N.D. Cal. 1985); *Eversole v. Metropolitan Life Insurance Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980).[13]

The resultant fragmentation of ERISA's enforcement and remedial scheme is thus quite real. Under the decision below, state common law rules which relate to employee benefit plans in general terms will survive preemption whenever an insurance company insures and assumes claims handling responsibilities for such plans. Plans insured and administered by insurers, but not self-funded or self-administered plans, will face the haphazard application of substantive standards embodied in varying state laws, in addition to or in lieu of those established in ERISA. Moreover, the former, and not the latter, will be exposed to the vagaries of state damages laws as well—including common law or statutory rules permitting extra-contractual or punitive damages. By allowing plan beneficiaries to sue under state common law or statutory rules for redress of conduct expressly regulated by ERISA, therefore, the decision below endorses pleading tactics, like those employed by the respondent in this case, clearly designed to escape ERISA's comprehensive remedial scheme and secure awards of extra-contractual and punitive damages—awards effectively foreclosed by this Court in *Massachusetts Mutual Life Ins. Co. v. Russell*, 105 S. Ct. 3085 (1985).[14]

[13] The decision in *Trogner v. New York Life Insurance Co., supra*, exemplifies the anomalous results spawned by this unworkable distinction. In that case, an employee sued her former employer and the insurer of its disability plan, alleging wrongful denial of benefits. Both the employer and the insurer asserted that the employee's common law claims were preempted by ERISA. Although the court held that the common law claims asserted against the employer "are precisely in the field which ERISA was intended to occupy", 663 F. Supp. at 507, and thus were preempted, the common law claims for breach of contract against the insurer were held not to be preempted because they regulated the business of insurance within the meaning of the saving clause.

[14] In *Russell*, this Court held that a plan fiduciary cannot be held personally liable under Section 409(a) of ERISA to a plan beneficiary for extra-contractual and punitive damages arising from an improper handling of a benefit claim. Although this Court did not address in *Russell* the availability of punitive damages under Section 502(a)(3) of the Act, some lower federal courts have recently held that punitive damages cannot be assessed under that provision. *See, e.g., Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, No. 85-2377 (5th Cir. July 14, 1986); *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d at 424.

This disruption of ERISA's carefully designed remedial scheme is far-reaching. If the decision below stands, the great majority of actions brought by plan beneficiaries for mishandling of benefit claims will be governed by state rather than federal law.[15] The uncertainty that such a fragmented system generates falls most heavily on the insurance industry, where the assessment of risks is fundamental to the decision to insure or to administer ERISA plans, and on employers who sponsor such plans. Faced with open-ended exposure to varying state law standards and remedies, these employers may be reluctant to adopt insured plans. Thus, the decision below puts pressure on employers to adopt self-funded and administered plans. This incentive to self-fund portends significant—and unintended—consequences in the employee benefit field. Although employees may be better protected by insured plans, the decision below encourages employers to self-fund, thereby subjecting the stability of these plans to the continued solvency of the employer. And employers who lack the resources to self-insure may choose to provide no plans at all. As aptly stated by one commentator:

[15] According to a survey prepared for the Department of Labor in 1980, approximately 91 percent of plans covering fewer than 100 participants, and 83 percent of plans covering more than 100 employees, are insured and administered by insurance companies. *See* "Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-79," Health and Population Study Center, Battelle Human Affairs Research Centers, Vol. IV (1980), at 43-45.

> [I]ntroduction into the preemption controversy of a distinction [between insured and self-funded plans] . . . would clearly discriminate against insurance companies in favor of self-insured plans, and thus strike at the very institutions which are stable and solvent providers of those very benefits that ERISA sought to protect. . . . [I]f followed, [this distinction] would be an incentive for employers to self-insure in order to avoid the myriad mandates of state insurance laws, even though by so doing they may be subjecting themselves to whatever standards the federal courts may dictate. This new aspect of the preemption controversy, the making of distinctions based not on the nature of the benefits, but on the provider thereof, exemplifies the far-reaching and disruptive results that are possible. . . .

Manno, "ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action," 52 Temp. L.Q. at 75 (1975).

As Congress surely recognized, the victims of this unwarranted distinction would be not only employers and insurers who undertake ERISA fiduciary responsibilities, but the very individuals ERISA was enacted to protect as well. There is no sound basis for construing ERISA to reach such a result.

CONCLUSION

The decision below should be reversed.

Respectfully submitted,

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APPENDIX

Statutory Provisions

Section 514 of the Employee Retirement Income Security Act of 1974 ("ERISA") provides, in pertinent part, that:

> (a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.
>
> * * * *
>
> [(b)] (2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> [(b) (2)] (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts. . . .
>
> * * * *
>
> [(c)] (1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. . . .
>
> [(c)] (2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 U.S.C. § 1144.

The McCarran-Ferguson Act provides, in relevant part, that:

> [1011.] Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.
>
> [1012.] (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance. . . .

15 U.S.C. §§ 1011-1012.